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Workers' Compensation and Managed Care

*An Introduction to the Principles of Managed Care and Their
Application in a Workers' Compensation Context*

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WORKERS' COMPENSATION and MANAGED CARE

Executive Summary

Section I of this report outlines the three predominate models of managed care organizations in the United States: the health maintenance organization (HMO), the preferred provider organization (PPO) and the point of service (POS) system.

The HMO model of health care delivery is broken down into the four predominant models that it can assume: the staff model HMO, the group model HMO, the network model HMO and the independent practice (or physician) association (IPA) model. The levels of integration and the unique characteristics of each of these HMO models are explained in detail, including each model's unique financial aspects, structural idiosyncrasies and key organizational components. The unique aspects of the PPO and POS models are also explained in detail in Section I.

Section II categorizes the defining principles of health maintenance organizations and preferred provider organizations into two distinct categories. Category One is comprised of basic managed care principles that, while important to the functioning of the managed care organization, are not uniquely important to the application of managed care in a workers' compensation context. These basic managed care principles include the following: integration, provider selection, provider reimbursement, credentialing and dispute resolution. Category Two is comprised of the three key managed care principles that are the defining characteristics of workers' compensation managed care organizations. These defining managed care principles are: workers' compensation managed care certification requirements, utilization review services (including peer review, case management and external review processes) and quality management services (including quality assurance and improvement). In order to garner a multi-jurisdictional perspective of the three key Category Two managed care principles, Section II of this report contains a comparison of statutes that define these three key managed care principles in six states.

Sections III and IV of this report are general discussions, with key literature references, of pharmaceutical services and accreditation services as they relate to managed care organizations. Section V is an introduction and discussion of the managed care purchasing pool model of health care delivery. Section VI addresses the concept of "24-hour coverage" programs and the application of these programs in California and other states. Section VII is a general literature review of general managed care and workers' compensation managed care articles.

I. MODELS OF MANAGED CARE HEALTH CARE DELIVERY SYSTEMS¹

a. HEALTH MAINTENANCE ORGANIZATIONS

b. PREFERRED PROVIDER ORGANIZATIONS

c. POINT OF SERVICE

a. Health Maintenance Organizations

Most contemporary Health Maintenance Organizations (HMOs) share certain common elements that distinguish their care from that of a traditional indemnity health plan, although different HMOs utilize a variety of structural models to provide that care. Most contemporary HMOs, as a general statement, are health care delivery models that seek to provide appropriate care in the most cost effective manner possible. HMOs seek to contain their costs (particularly as compared to a fee-for-service system) in three primary ways.² First, HMOs seek to reduce the frequency and scope of services utilized by their members.³ Reducing costs by managing utilization is discussed in detail in the utilization review (UR) section of this paper. Second, HMOs seek to reduce costs by paying providers and other contractors less than they would pay for the same services under a fee-for-service system.⁴ This cost saving phenomena is discussed in detail in the section of this paper titled *Provider Selection (Use of a Restricted Provider Network)*. Third, HMOs seek to garner additional cost savings by enrolling relatively healthier members that need fewer health care services.⁵

As discussed below, HMOs can assume several different models (staff model, group model, network model, IPA model, among others) through which they seek to provide care in a cost efficient manner. Each model can result in cost savings through its unique structure. For example, staff and group model HMOs receive discounts of twenty-five percent from their standard charges (presumably fee-for-service charges) by concentrating patients in a relatively small number of hospitals.⁶ IPAs, under the IPA HMO model, are also able to achieve discounts, albeit smaller than those enjoyed by the staff or group model due to their broader contracting network.⁷ The specific cost saving aspects of each of the various HMO models are outlined below in the detailed discussion of each HMO model type.

Peter R. Kongstvedt, in his leading treatise on managed care, outlines the primary models through which managed care benefits can be provided.⁸ Four of these HMO models that are most common in California are as follows: the staff model HMO, the group model HMO, the network model HMO, and the independent physician association (IPA) model HMO.⁹ Although each one of these models has certain unique traits, the fundamental difference between them is how each model relates to its

¹ The descriptions of the various models of care (including HMOs, PPOs and FFS systems) in this paper substantively rely on the following two publications: Health Care USA Understanding Its Organization and Delivery, Third Edition, Harry A. Sultz, DDS, MPH & Kristina M. Young, MS, Aspen Publishers, Inc., 2001, and The Managed Health Care Handbook, Second Edition, Peter R. Kongstvedt, MD, FACP, Aspen Publishers, Inc., 1993.

² Christianson Jon, Can HMOs Contain Workers' Compensation Medical Care Costs? at 149 (this article is a chapter appearing in Review, Regulate, or Reform? What Works to Control Workers' Compensation Medical Costs, Workers' Compensation Research Institute, Thomas W. Grannemann, Editor 1994).

³ Id.

⁴ Id.

⁵ Id.

⁶ Id.

⁷ Id.

⁸ The Managed Health Care Handbook, Second Edition, Peter R. Kongstvedt, MD, FACP, Aspen Publishers, Inc., 1993.

⁹ Arguably, there is one other HMO model that is generally referred to as the "direct contracting" model by which the HMO contracts directly with a provider. Jonas's Health Care Delivery in the United States, 5th Edition, Anthony R. Kovner, PhD, Springer Publishing Company at 127.

participating physicians¹⁰ and the fact that the physicians often assume some amount of financial “risk” in the care of their assigned members. Although these models, and their cost saving components, are discussed below in four distinct categories, many HMOs do not provide services under a single model but borrow elements, as needed, from other models to provide services to their members.¹¹

1. The Staff Model HMO

As the name implies, the physicians and other health care providers of a staff model HMO are the employees (that is, the “staff” members) of the HMO.¹²¹³ An example of a staff model HMO is the Group Health Association.¹⁴

The staff model HMO is a highly integrated health care delivery system, blending together the financing of the care (collecting premiums from either the employer or the individual and paying for the services of the providers) with the delivery of the care (by staff providers).¹⁵ This integration of financing and care is enhanced by the fact that a staff model HMO refers patients to other providers within their closed system of staff providers, assuming that the staff model HMO employs an adequately broad staff of primary care physicians, specialist physicians and ancillary providers.¹⁶ By providing health care services within the closed system of providers (i.e., within the “closed system” of staff providers) the staff model HMO can more tightly control the practice and utilization patterns (and costs) of the care rendered to its members.¹⁷

Providers in a staff model HMO traditionally are paid a base salary for providing services to the HMO members.¹⁸ This method of compensation is very different from physicians that provide services in a fee-for-service system, where compensation is based on the frequency and complexity of procedures. In a fee-for-service system, the income of a physician is directly proportional to the frequency and complexity of services¹⁹ rendered by that physician, thereby creating an incentive to over-treat or over-prescribe. Over-utilization, and the resulting high costs of unnecessary or excessive services, is a common lament of a fee-for-service delivery system. These high costs are commonly linked to, or labeled as, health care fraud in the workers’ compensation and general health care arenas.²⁰ By comparison, in a staff model HMO, such an incentive to over-treat and over-prescribe is less common because providers are paid a salary, that is, their compensation is unrelated to the volume or complexity of procedures or services. As there is no incentive for the providers to overprescribe care in a staff model, utilization rates tend to be lower with proportionately lower costs. However, in a staff model HMO, the close integration between financing care and providing care (where the HMO itself

¹⁰ Kovner at 127.

¹¹ Hybrid HMOs, that is, HMOs that combine several models, are commonly referred to as mixed model HMOs, where, for example, the physicians that comprise the provider panel of the HMO are both staff model and contracted IPA physicians.

¹² The Managed Health Care Handbook, Second Edition, Peter R. Kongstvedt, MD, FACP, Aspen Publishers, Inc., 1993.

¹³ Curing the Crisis, Options for America’s Health Care, Michael D. Reagan, Westview Press, at 18

¹⁴ Kongstvedt at 17.

¹⁵ Id.

¹⁶ The above statement notwithstanding, there may be a certain level of communication (and thus integration) between the various providers that treat in a fee-for-service system. This level of communication is generated by providers that consider it good clinical practice to establish and maintain an open line of communication, between the treating physician and the referring physician, with regard to clinical matters. That said, this level of integration is far less than that of a staff model HMO or MCO.

¹⁷ Kongstvedt at 17.

¹⁸ Id.

¹⁹ Kovner at 127.

²⁰ Health Care USA Understanding Its Organization and Delivery, Third Edition, Harry A. Sultz, DDS, MPH & Kristina M. Young, MS, Aspen Publishers, Inc., 2001, at 260.

may profit with less care rendered) may help create financial incentives to under-treat or under-prescribe care.

Costs are also lowered in a staff model HMO because the vast majority of care - if the HMO has an adequately broad network of specialist and primary care physicians - can be delivered in network by other providers who are salaried and likewise do not have an incentive to over-prescribe care. However, while it is the goal of a staff model HMO to integrate as many health care services as possible for their members, it is not possible to integrate all the services for all of their members at all times. For example, integration in a staff model breaks down when the staff model needs to refer a member “out-of-network” because needed expertise (such as occupational specialists) is unavailable within the ranks of the staff providers. Such out-of-network referrals tend to raise costs. The need for members to access emergent and urgent services outside their HMO also may preclude the direct use of services from the staff model HMO, and these services tend to be more readily sought because a staff model generally cannot broadly saturate a market with enough emergency facilities.²¹

2. The Group Model HMO

In a group model HMO, the care rendered to members is provided by a multi-specialty group of physicians.²² The physicians in the group, which is most commonly a large and diverse body of physicians, are not employees of the HMO but instead are employees of a physician group.²³ Under the traditional group model structure, the group model physicians share the physical facilities through which care is rendered to members (e.g., office equipment, clinic facilities, hospitals (if the group model is large enough a hospital system), support staff, etc.).²⁴ The group model physicians can be reimbursed either through capitation²⁵ or through a cost system.²⁶ Generally, group model HMOs are “closed panel” HMOs, as the physicians are commonly required to be part of the group practice to provide care to the HMO members. In other words, the panel is closed to physicians outside of that particular physician group.²⁷

Like the staff model, one of the advantages to a group model HMO is the high level of integration between the financing and the provision of services. With such a high level of integration, it is generally easier to control care through utilization management processes, which results in lower costs. These utilization lowering processes include the use of utilization guidelines (often developed by the group), group-based utilization review committees, peer review committees and case management systems, all of which work toward controlling the costs of care. A further advantage to the group model is the fact that as the HMO is not the direct employer of the physicians, the HMO does not have to shoulder the burden of meeting the monthly salary demands of the physicians. Instead, this financial obligation is met by the group.²⁸

²¹ Most HMO models preclude members from access to *non-emergent* or *non-urgent* services by excluding or limiting coverage for these services if, under the general legal standard of reasonableness, the member knew or should have known that the accessed services did not require emergent or urgent care.

²² Kongstvedt at 18.

²³ Id.

²⁴ Kongstvedt at 18.

²⁵ Generally, under a capitated system the costs of care for a member are paid out of a single lump sum payment (usually on a per member, per month basis) that is paid to the primary care physician or group of physicians.

²⁶ Kongstvedt at 18.

²⁷ Id.

²⁸ Id (Kaiser is classified as a group model HMO because the physicians in the Kaiser system are employees of the Permanente Medical Group.)

Although the group model may be able to control utilization more effectively than a more loosely integrated delivery model, the disadvantages of a group model, like a staff model, include the fact that the panel of physicians is often somewhat limited in its breadth of specialties²⁹ and as group model physicians often share physical facilities the number of convenient facilities available to members can be somewhat limited.³⁰ Again, the staff and group models are very good at containing costs as long as the care is kept within the contractual confines of the staff or group model providers and facilities.

3. *The Network Model HMO*

The network model HMO is distinguished from the group model HMO in the fact that under the network model the HMO contracts directly with a network of medical group practices, rather than a single medical group.³¹ Whether the network model contracts with several large multi-specialty groups, or a number of smaller groups of primary care physicians (a primary care network model), the network model offers greater flexibility than the group or staff models, and often a broader choices of physicians.³² With this flexibility, however, the level of integration is reduced, the control over the utilization tends to diminish and the costs of care rise. This lack of integration partly lies in the fact that network model HMOs can be “open” panel plans, where any physician who meets the credentialing criteria of the HMO and group can join.³³ However, because the network model HMO does not necessarily share all of the same physical facilities or the same physical locations as a group or staff model HMO, the network model HMO is able to cover a broader territory and offer to its members a wider array of physicians from which to access services.³⁴

4. *The Individual (Independent) Practice Association (IPA) Model HMO*³⁵

The individual practice association (IPA) model is one of the dominant HMO models used in California, particularly in Southern California.³⁶ In the IPA model, the HMO contracts with independent physician associations (IPAs) which are separate legal entities from the HMO. These IPAs, in turn, provide physician services to their members.³⁷ The physicians that comprise the IPAs often house their own patient’s medical records, maintain their own offices (separately from the HMO and the IPA), and are able to see non-HMO patients.³⁸ Although there is some variation in the requirements of different HMOs, most of the HMOs in California that utilize the IPA model require their members to select a PCP (the gatekeeper) from a particular IPA. Care for that member is then coordinated by the chosen gatekeeper PCP, within the IPA provider network whenever possible. Most routine care can be rendered within an adequately composed IPA panel of physicians, as the physician composition of the IPA is usually broad in both primary care and specialist physicians.³⁹ The tendency

²⁹ Kongstvedt at 19.

³⁰ Kongstvedt at 19.

³¹ Id.

³² Id.

³³ This open panel can be compared to a more integrated closed panel, where physicians must be part of a limited number of group practices (*see* Kongstvedt at 19).

³⁴ Kongstvedt at 19.

³⁵ In Southern California, and increasingly in other parts of the United States, the term Individual (or Independent) Practice Association is synonymous with Individual (or Independent) *Physician* Association. Both terms are used interchangeably in this paper.

³⁶ The financial stability of the IPA Model in California has recently come under question, spurred on by the highly publicized bankruptcies by several large IPAs. In addition, the California Legislature passed legislation in the year of 2000 (SB 260) that, in conjunction with the California Department of Managed Health Care (which provides oversight of HMOs in California), oversees the financial solvency of the complete system of HMO, and in particular the IPA model.

³⁷ Kongstvedt at 19.

³⁸ Id.

³⁹ Kongstvedt at 20.

of physicians to refer to other physicians within the IPA⁴⁰ is for both financial reasons (as the other physicians in the IPA physicians may have agreed to accept a lower reimbursement level) and coordination of care reasons (where the physicians in the IPA have better coordination of care, they may build a better working relationship and working rapport with the doctors to whom they regularly refer patients). In addition, as IPA physicians are generally private practice physicians who have multiple HMO or PPO contracts, members are often able to choose a PCP with whom they have had a previous relationship through another insurer.

IPAs may or may not have an association with a particular hospital, or the IPA may have grown out of a group of physicians that were on-staff or otherwise associated with a hospital.⁴¹ Some HMOs require that when their members choose a particular PCP who is associated with an IPA, that member is then assigned to the hospital that is associated with that IPA. By having the member choose a PCP (and thus IPA and hospital) through which their care is coordinated, the member's physician care (both primary and specialty) and hospital care can be provided in a more coordinated fashion and at a lower cost due to the contractual relationship between the IPA and the hospital.

By binding together in an IPA, physicians can negotiate with the HMO to treat a much larger number of patients. This results in lower reimbursement rates for these physicians than if they had billed the HMO as a solo or small group practitioner.^{42,43} However, those physicians are guaranteed a much higher volume of patients as designated providers on an IPA panel. This unique contractual relationship results in the HMO being able to provide services in a very cost effective manner.⁴⁴

In addition, in an IPA model, the HMO enjoys the operational efficiency (and thus lower costs) of being able to disseminate information (policies, procedures, utilization standards, etc.) directly to the IPA rather than to each physician in the IPA. The IPA, in turn, passes that information to the individual providers. However, because a separate legal entity (the IPA) separates the providers from the HMO, it is more difficult for the HMO to disseminate information to all providers (utilization management guidelines, quality management guidelines, etc.) and to establish consistent practice patterns to coordinate the utilization of care.⁴⁵ Thus, the utilization of care, and the resulting costs due to that utilization, is generally higher in an IPA model than in a staff, group or network model.

b. The Preferred Provider Organization Model of Health Care Delivery

Under the traditional model of a preferred provider organization (PPO), the health plan contractually develops a network of providers from which the member can access care.⁴⁶ Members of the PPO generally are not required to select a primary care physician to act as a "gatekeeper" to access specialist care, as they would with an HMO.

Although not required to choose a primary care "gatekeeper" in a PPO, and although the member is afforded more flexibility to choose a provider than in an HMO, her choice is not limitless. Rather, she

⁴⁰ Id at 20.

⁴¹ Id at 20.

⁴² In a direct contract relationship (sometimes referred to as the direct contract model), the HMO contracts directly with individual physicians who are community-based physicians engaged either as solo practitioners or in small group practices, usually comprised of several primary care physicians or a small group of specialists. The level of integration and coordination of care in a direct contract model is the lowest of any HMO model, given the relatively loose associations between physicians.

⁴³ Kongstvedt at 20.

⁴⁴ Id.

⁴⁵ Id at 21.

⁴⁶ Kovner at 127.

must choose a provider from a pre-designated panel of “preferred providers.”⁴⁷ These preferred providers are generally comprised of physicians (or groups of physicians) who have contracted with the plan to accept a pre-negotiated fee for services and to abide by any additional policies and procedures set by the plan.⁴⁸ By not having a gatekeeper physician (as with an HMO), the management of care is not as tightly controlled as in an HMO. In addition, providers in a PPO generally do not assume any financial “risk” for the care of their patients because they are paid a discounted rate.⁴⁹ This lack of utilization control usually results in a higher utilization of care and additional costs. Thus, in general, the utilization of care received in a PPO, and thus the costs of that care, is higher than that of an HMO.

The policies and procedures by which the providers contractually agree to abide in the treatment of their PPO members generally include some managed care concepts such as a utilization review (UR),⁵⁰ quality management (QM), credentialing, and dispute resolution (DR) among others.⁵¹ In more sophisticated and highly integrated PPOs (that is, those that require organized requirements for UM, QM, DR, etc.), the relationship between the provider and the PPO takes on the characteristics similar to those between a provider and an HMO.⁵² However, as stated above, PPO care is generally more expensive (as compared to an HMO) due to more lax management of the utilization patterns.

Under a PPO model of health care delivery, a provider has usually contractually agreed to accept a lower schedule of reimbursement for the services they provide to the PPO members (compared to their FFS members).⁵³⁵⁴ These lower fees, however, are offset by the fact that the PPO panel of providers will generally receive a higher volume of patients seeking that provider’s services as the PPO members are limited to the providers on the PPO panel.⁵⁵ In other words, the preferred provider trades a lower reimbursement schedule for a higher volume of patients, although the volume of guaranteed patients is not as high as with an HMO. To keep providers from over-utilizing or over-prescribing care, which in turn generates higher costs, the PPOs often implement incentives to lower utilization. These incentives can include “risk pools,” where the provider receives a financial bonus from a predetermined pool of money if utilization is kept to an appropriate level.⁵⁶ As an additional incentive for a provider to become a panel provider in a PPO, preferred providers will also generally receive reimbursement much more quickly than a FFS physician.⁵⁷ This quick reimbursement is borne out of the fact that most fees are contained in the fee schedule, so there is less negotiating for reimbursement levels.

One of the key distinctions between an MCO that provides managed care health insurance benefits and an MCO that provides managed care workers’ compensation benefits is the fact that the states generally require that beneficiaries in workers’ compensation systems are entitled to unlimited health

⁴⁷ Kongstvedt at 14.

⁴⁸ Id at 14.

⁴⁹ Kovner at 127.

⁵⁰ As a general rule, most workers’ compensation managed care organizations, as well as health care workers’ compensation organizations, include the concept of peer review and case management under the general organizational terms of Utilization Review or Utilization Management.

⁵¹ Kongstvedt at 14 (*see also* Kovner at 127..

⁵² Id.

⁵³ The act of charging a member (whether a member of a PPO, HMO or FFS) for the balance, or differential, between a negotiated amount of reimbursement and the provider’s actual charge is termed “balance billing”. As noted above, in a PPO, the PPO providers generally agree to accept the negotiated fee schedule as “payment in full” for the services rendered.

⁵⁴ Kongstvedt at 14.

⁵⁵ Id.

⁵⁶ HMOs (particularly in the IPA model) also use techniques such as risk pools to manage care and control costs.

⁵⁷ Kongstvedt at 14

care benefits for injuries that are proximately linked to the compensable injury without any financial contribution from the injured worker. Managed care health insurance, including PPOs, by contrast, commonly requires deductibles, coinsurance and copayments, and otherwise allows reasonable limitations and restrictions on some medical benefits. These types of member contribution to the overall cost of care are commonly used as incentives to either shift the cost of the care to the member or help control utilization due to the member's required financial contribution. These patient contributions have been shown to reduce utilization, and thus reduce costs, but such financial contributions by the patient, whether to be used as utilization controls or otherwise, are generally not allowed in workers' compensation jurisdictions.

c. The Point of Service Model of Health Care Delivery

Point-of-service (POS) plans combine managed care elements of HMO and PPO plans⁵⁸, as well as traditional indemnity elements of FFS plans. The combination gives POS members increased flexibility in their selection of providers. However, with this increased flexibility, the costs of a POS system are generally higher. Although not as prevalent as HMOs and PPOs, the POS model is a fairly recent alternative delivery system but its popularity, primarily due to the greater options in physician choice, is growing in the health care marketplace. POS plans are sold either as stand-alone health plans, or as riders to an HMO or PPO plan.⁵⁹

The primary differentiating component of a POS plan is the fact that a member is able to receive services, usually with some limitations, from a provider that is not a member of their PPO panel or HMO panel of physicians.⁶⁰ Nor is care under a POS plan coordinated, again with limitations, by a primary care physician.⁶¹ However, the share of cost borne by the member for services provided under the POS portion of the plan is higher.⁶² Nonetheless, it is a strong marketing advantage for plans that offer a POS line of business to offer to their prospective members the option of receiving out-of-network care at a higher price than in-network care but less expensively than paying the out-of-network provider's complete fee. Furthermore, as most POS plans are sold *in addition* to the member's HMO or PPO plan, the member has the option to seek care from their in-network provider at a lesser amount (usually a copayment amount each time they see their provider) and reserve their use of the more expensive POS benefit (usually a percentage of the out-of-network provider's charges)

⁵⁸ Kovner at 128.

⁵⁹ For a detailed comparison of services accessed under a POS health care system to services accessed under an closed panel HMO system, please see *Expenditures for Physician Services Under Alternative Models of Managed Care*, Kanika Kapur, Medical Care Research and Review, Volume 57, Number 1, pages 161-181, March 2000, by Geoffrey F. Joyce, Krista A. Van Vorst and José J. Escarce. This study was a detailed comparison of physician services expenditures in a closed panel HMO with physician services expenditures in an open panel point of service HMO. By comparing administrative files under various plans with varied copayment amounts, the authors concluded that, contrary to their expectations, that the data did not reflect that expenditures for specialists' services or total physician services in the point of service HMO plan were higher than the closed panel HMO plan. The authors noted that "direct patient access to specialists does not necessarily result in higher physician or specialist expenditures in HMOs", and that recent tendencies to expanding patient choice in the selection of the providers was the result of the fact that higher patient satisfaction is linked to provider selection.

⁶⁰ Kongstvedt at 15.

⁶¹ *Id.*

⁶² For an examination of point of service in a managed care plan, please see *A Case Study of Point-of-Service Medical Use in a Managed Care Plan*, Medical Care Research and Review, Volume 56, Supplement 2, 1999, Pages 85-110, by HS Wong, and L. Smithen. This study uses proprietary claims data looks at expenditures of an IPA model plan that out of network care represented approximately twelve (12) percent of the claims reviewed, which accounted for approximately nine (9) percent of the cost of those claims, and that younger members accessed more out-of-network care, most often for specific types of services, such as mental health.

when seeking a second opinion or for their convenience.⁶³ Some plans limit the benefits allowed under the POS model to outpatient physician services only (with some limited, noninvasive diagnostic services allowed as well), while other plans allow members to receive the full range of benefits allowed under their HMO or PPO plans.

As noted above in the PPO section of this report, one of the key distinguishing differences between a health care HMO and PPO and a workers' compensation HMO or PPO is that workers' compensation systems generally do not allow any financial contribution by the injured worker for the provision of her compensable medical care. As such, the fundamental conceptual framework of a POS plan - that a member can seek care outside of the pre-designated panel of providers - appears incompatible with the general rule in workers' compensation that the injured worker should pay nothing for her medical care.

However, assuming for the sake of argument that it may be desirable to allow for a modified POS model to be applied to a workers' compensation managed care setting, such an offering would may be useful to counteract the fact that the provider selection is more limited under a managed care plan. Being unable to seek care from any provider, as is more common under a FFS plan, is a common complaint about managed care organizations (MCOs).^{64,65} Giving injured workers the option to seek care beyond the HMO or PPO panel of providers through a POS option helps to address that concern. On the other hand, allowing workers to access care, for an additional fee, from providers outside of a pre-determined network would give workers with a higher average weekly wage, or an additional source of income, to have access to a broader, and possibly better, network of physicians. Such a system may, in turn, create a two-tiered system of workers' compensation providers, where wealthier workers have broader and better access to medical care.⁶⁶

II. CATEGORIZING THE BASIC PRINCIPLES OF HMOs AND PPOs

As two of the predominant managed care delivery systems in the United States, and particularly in California, PPOs and HMOs provide health care services to millions of Americans. Though different in many respects, both the HMO and PPO models of health care delivery share the same fundamental purpose, that is, to provide health care services to the participants of their system.⁶⁷ Another similarity between HMOs and PPOs is that each utilizes a similar core set of health care delivery principles to provide care to their members, though different models of HMOs and PPOs (see discussion of various HMO and PPO models, *supra*) utilize these principles in varied degrees. It is the varied use of these

⁶³ Kongstvedt at 15.

⁶⁴ The acronym "MCO" will commonly be used as an abbreviation for "Managed Care Organizations", which is a generic term that includes all models of HMO, PPO and POS organizations.

⁶⁵ California recognizes that the perceived lack of choice in a managed care plan, at in the workers' compensation context, is of enough concern that an employer must offer a traditional fee-for-service plan if that employer wants to offer a managed care plan to their employees who suffer compensable injuries.

⁶⁶ Alternatively, injured workers' could be given access beyond that of their pre-designated managed care panel by having a process by which a worker would be given the option to opt-out of the managed care system and into a traditional FFS system, without any additional financial contribution by the worker, if she feels that her access is being inappropriately limited by the managed care system. By allowing a worker to opt-out of the system by demonstrating a bona fide issue with her managed care plan, that worker could be given full access to her provider of choice once the managed care system, in the eyes of a workers' compensation judge, has failed to address the needs of the worker. California addresses this issue somewhat by requiring a managed care organization that provides workers' compensation managed care services to offer both a FFS plan and a managed care plan to employers.

⁶⁷ Although this paper emphasizes the application of managed care principles in the workers' compensation arena, and specifically in an HMO and a PPO, comparisons are drawn to a traditional FFS indemnity system to illustrate how managed care systems differ from a FFS system.

core concepts that differentiates the care provided by an HMO from the care provided in a PPO system, or from the care provided in a FFS system.⁶⁸

This report bifurcates managed care delivery principles into two categories. **Category One** principles are comprised of general managed care principles that apply both to those MCOs that provide health care benefits and MCOs that provide workers' compensation benefits. The application of Category One principles does not significantly change in their application in a workers' compensation context, as compared to a general health care context. As such, these principles are discussed in more general terms, and less in a workers' compensation context. These five basic MCO principles include the following:

- a. The integration of the financing and delivery of health care services
- b. The method of provider selection
- c. The method of provider reimbursement
- d. The method of provider credentialing
- e. The method of dispute resolution

Category Two contains three managed care principles that are three of the key managed care concepts in a *workers' compensation managed care system*. These key managed care aspects, as applied to workers' compensation systems, include:

- f. The process by which states certify an MCO for the purpose of providing workers' compensation managed care services
- g. The utilization management services provided by the workers' compensation MCO (including peer review and case management services)
- h. The quality management services of the workers' compensation MCO (including quality assurance and improvement)

These three principles provide the key structural, procedural and outcome aspects of the operation of an MCO in a workers' compensation setting. As such, this report contains a detailed comparison of these three key workers' compensation managed care concepts, as mandated by the workers' compensation managed care laws of six states.

Category One (General Managed Care Principles)

a. *The Integration of Services and Financing in an MCO (compared to fee-for-service)*

One of the defining differences between fee-for-service (FFS), preferred provider organization (PPO) and health maintenance organization (HMO) systems of care is the level of integration between the financing and delivery of the health care delivery system.⁶⁹ As noted in the discussion of various MCO models, FFS systems are the least integrated of the three models. A PPO system is somewhat more integrated than a FFS system, and a contemporary HMO is the most integrated system of the three. The integration process incorporates and coordinates both the structural and procedural aspects of a health plan's operations, to help provide more efficient care in a more coordinated fashion.

⁶⁸ In this paper, the core set of health care services concepts presented as those that characterize a FFS, HMO or PPO system builds a general framework for classifying these three systems of health care delivery, and should not be thought of as absolute lines of demarcation between these systems, though the general systems of classification are accurate. In application, particularly in an evolving health care delivery market, FFS, HMO and PPO health care systems often borrow ideas from alternative delivery systems and integrate them, to some degree and with some changes, into their system.

⁶⁹ Health Care USA Understanding Its Organization and Delivery, Third Edition, Harry A. Sultz, DDS, MPH & Kristina M. Young, MS, Aspen Publishers, Inc., 2001 at 260.

In a fee-for-service (FFS)⁷⁰ health care delivery system, the health plan collects the premiums from the member, or the employer, and the member seeks care from the provider of her choice. In other words, the member, with some restrictions, chooses the scope and volume of services, as well as the provider[s] that render those services. After the services are rendered, the provider submits a claim to the indemnity insurer, and the insurer pays either the provider's billed charges or a negotiated amount (commonly the usual and customary amount for a particular procedure in that provider's community). As such, in the fee-for-service system, there is little to no integration by the health plan of the financing (collecting premiums and paying provider claims) and the delivery of services (where the member selects the provider and controls the utilization of services).

In a preferred provider organization (PPO), the level of integration between the financing of health care services and the delivery of those services is somewhat more integrated than in a FFS system. In a PPO system, the member (or the member's employer) is afforded flexibility in the choice of providers although their choice is limited to a pre-designated panel of "preferred providers." The member is allowed to select the provider from the panel of preferred providers, and, as such, the treating provider must submit a bill to the plan. Often, the PPO preferred providers agree to abide by a limited set of utilization and quality policies and procedures set by the PPO plan. The PPO plan may require a prospective provider, as a condition precedent to being listed on the preferred provider panel, to undergo certain quality orientated reviews (including a review of the facility where that provider will treat members and a review of the provider's credentials). Thus, a PPO plan provides a higher level of integration of the financing structure (premium collection and provider reimbursement) and the delivery of care than does a FFS system.

In a health maintenance organization (HMO) delivery system, the financing of health care services and the delivery of those services is much more integrated than in a PPO or FFS system. An HMO, as does a FFS or PPO system, collects premiums from either the individual or her employer. However, the care rendered in an HMO system is not rendered by any provider that the member selects (as in a FFS system), or by any provider on a PPO panel. Rather, the member is required to first access care from a particular pre-designated primary care physician (the "gatekeeper"). That gatekeeper then coordinates the care of the member within a certain group of designated physicians that is pre-selected by the member from a particular providers group, which is usually one of many subgroups within the HMO's complete provider directory. As such, the integration of the financing of services and the delivery of those services is appreciably greater in an HMO than in a traditional indemnity or PPO system. In other words, by comparison, under a pure FFS system, the plan collects premiums from the member (or employer) and a provider of the member's choosing provides the health care services.⁷¹ That provider then submits a bill to the indemnity insurer and the provider is reimbursed for those services.⁷²

⁷⁰ A fee-for-service health care delivery system (FFS) is also commonly referred to as "indemnity insurer".

⁷¹ Some traditional indemnity insurers require their members to seek care only from those providers who agreed to accept a pre-negotiated amount as "payment in full" for the services rendered and, in these cases, members were allowed to choose any physician (primary care or specialist) from that list of providers.

⁷² One of the key distinctions between an MCO that provides managed care *health insurance* benefits and an MCO that provides managed care *workers' compensation* benefits is the fact that the states generally provide unlimited health care benefits for compensable injury or disease without any financial contribution by the injured worker. Health care MCOs generally require copayments and deductible. However, such financial contributions by the patient, whether to be used as utilization controls or general cost of care reimbursement, are generally not allowed in workers' compensation systems in the United States, where health benefits for compensable injuries are provided whenever needed.

Category One (General Managed Care Principles)

b. *Provider Selection (Use of a Restricted Provider Network)*

In a pure FFS system, a member has the ability to select her provider of choice. Although such a statement suggests a limitless choice of providers, the choice is rarely so broad. One of the key limits of a FFS member's selection of provider is the willingness of the provider to accept as payment the amount of reimbursement that the FFS insurer is willing to pay for a particular service. Depending on the amount of reimbursement that the FFS will pay, particularly if the historical reimbursement rates by a FFS insurer are lower than desired by the provider, the patient's access may be limited to providers who have agreed to accept the low reimbursement rate. This can be common if the patient is attempting to access care in a fee-for-service system that has adopted broad reimbursement schedules. Reimbursement schedules, which are more common in large statewide FFS programs such as workers' compensation and Medi-Cal, may be so low that providers will opt not to treat those patients, thereby diminishing access. This lack of access in a FFS system may be particularly acute if providers are statutorily prohibited from billing the patient for the difference between their charges and the scheduled reimbursement rate.⁷³

In a PPO, provider selection is within the choice of the member, albeit the member must choose her treating physician from among the panel of preferred providers. However, the member, with little restrictions, can generally access care from any of the physicians on the panel, whether primary care or specialist care.

In the contemporary HMO model, provider selection is one of its most distinguishing features. Most contemporary HMOs require that a member choose, from among a closed panel of pre-designated physicians, a single primary care physician (PCP) as a "gatekeeper" to specialty care. As the gatekeeper, the PCP is in the position to use her generalized knowledge of medical matters to refer members to the correct specialists, as needed. Significant cost savings have been noted by controlling access to providers through the use of PCPs.⁷⁴ For instance, a review of workers' compensation managed care plans reflected that the use of PCPs are "associated with a 23% - 29% drop in the average total cost per claim, with 7% - 8% of those savings attributed to a decrease in lost work time."⁷⁵

The use of a PCP gatekeeper in an MCO is clearly distinguished from the fee-for-service system where the member is free to utilize the provider of her choice, specialist or otherwise, as long as the services are medically necessary and covered benefits. It has been suggested that a PCP gatekeeper in a workers' compensation context is less than optimal given the fact that workers' compensation injuries quite often involve emergency events and, as such, it is impractical for a worker to seek care from her PCP.⁷⁶

⁷³ If the fee-for-service reimbursement schedule is too low, and thus not accepted by a majority of providers, access to care in a fee-for-service system can be greatly hindered. For example, in California the low Medicaid reimbursement level resulted not in an abundant selection of providers, but rather required the patient to begin a process of finding a physician who accepted the low reimbursement rate.

⁷⁴ Managed Care in Workers' Compensation Plans, Pamela B. Peele and David J. Tollerud, 22 Annual Review of Public Health at 9.

⁷⁵ Id at 9-10 (citing to Greenberg EL, Leopold R. 1998. Performance measurement in workers' compensation managed care organizations. *Occup. Med.* 13(4):755-72 and Dembe AE. 1998. Evaluation the impact of managed health care in workers' compensation. *Occup. Med.* 13(4):799-821).

⁷⁶ Id at 9.

As noted above, MCOs (both PPOs and HMOs) utilize some sort of restricted provider network that seeks to treat most, if not all, of the medical problems of the members of the MCO. The providers in the MCO's restricted network serve this large patient pool (presumably larger than they would see as individuals), which they treat at a lower cost to the MCO. In other words, the MCO is able to focus its sizeable pool of members toward a select group of physicians who have agreed to accept a lower rate of reimbursement because they know their patient population is effectively guaranteed. The economies of scale enjoyed by both the MCO and the provider network result in large cost savings that managed care brings to a workers' compensation or general medical system.⁷⁷ These cost savings will generally tend grow in proportion to the size of the network and the patient population, that is, the larger the patient pool the larger the cost savings.⁷⁸

This dramatically increased bargaining leverage has given MCOs, particularly in regions of California that have a heavy managed care presence, tremendous bargaining position over the provider community. As such MCO reimbursement rates remained steady for many years, and in some cases dropped, during the past decade while other health care expenditures have risen well above the general rate of inflation.

However, despite the dramatic cost savings enjoyed by MCOs that use a restricted provider network (both through better bargaining power and more efficient utilization), there is evidence that the use of restricted provider networks may result in a lower level of satisfaction due to the fact that workers are unable seek care from their provider of choice.⁷⁹ Workers' compensation managed care plans in Florida, Oregon and Washington have been shown to provide equal levels of care but lower levels of satisfaction due to a lack of provider choice.⁸⁰

Category One (General Managed Care Principles)

c. *Provider Reimbursement*

If the reimbursement level is not pre-determined in a set fee schedule, the reimbursement of a provider for services rendered in a FFS system is accomplished through the submission of a claim for services (a billed charge) to the carrier, commonly limited to the reasonable and customary (or prevailing) fees charged for similar services in that provider's community.

In a PPO, the preferred panel of physicians has generally contractually agreed to accept a pre-negotiated rate of reimbursement per procedure that reimburses the preferred provider for each procedure or service that she performs. The pre-negotiated price that the PPO preferred providers, or groups of providers, has agreed to accept is usually lower than that provider's FFS rate for the same procedure or service. Thus, the PPO provider reimbursement methodology, like the HMO reimbursement methodology, also provides cost reducing tools.

⁷⁷ Id.

⁷⁸ Arguably, the greater bargaining position of MCOs over their providers is the primary force that has, for almost a decade, kept health care premiums from increasing at a rate that is comparable to the medical inflation rate. As noted in this paper, many fee-for-service workers' compensation systems now use utilization management techniques to control the utilization of care, particularly for expensive procedures and services, in a way this is similar MCO's management of utilization. Therefore, it is hypothesized, if both fee-for-service organizations and MCOs use similar utilization control process, then the only substantive difference that can possibly account for the lower cost of care in an MCO (as compared to the cost of care in a fee-for-service organizations) is the superior bargaining power of the MCOs.

⁷⁹ Id.

⁸⁰ Id (citing to Dembe AE. 1998. Evaluating the impact of managed health care in workers' compensation. *Occup. Med.* 13(4): 799-821 and Kyes KB, Wickizer TM, Franklin G, Cain K, Cheadle A, et al. 1999. Evaluation of the Washington state workers' compensation managed care pilot project I. *Med. Care* 37(10):972-81).

HMOs provide a set of covered benefits for their members through a pre-determined panel of providers. The reimbursement of these providers is often not based upon procedure or service, but on a fixed-sum amount. That fixed-sum (commonly referred to as “capitation”) amount of reimbursement is paid monthly to each physician, or to a group of physicians, and is often based on the basic demographic characteristics (sex, age, region, etc.) of the members assigned to that physician or group of physicians. There can be additional sources of income based on utilization patterns (risk pools, withholds, etc.), but the primary component of reimbursement for most HMOs is the monthly capitation payment. As noted in the description of the various models of HMOs, provider reimbursement through capitation or salary payment provides a powerful economic incentive to not over-treat or over-prescribe care for the simple reason that a provider’s compensation is not proportional to the volume of procedures performed. Thus, the HMO’s provider reimbursement system (capitation) offers a powerful cost saving tool.

Category One (General Managed Care Principles)

d. *Credentialing*

“Credentialing” of a provider is the process by which the health plan verifies whether a provider has certain appropriate credentials, such as licensure, board certification, completion of residency requirements, admitting privileges, etc. Credentialing is a concept that is only minimally applied in a fee-for-service system for the simple reason that the member is free, within reason, to access care from nearly any provider. As such, a fee-for-service health plan is generally be unable to identify the provider that the member will choose prior to the member accessing the care. In addition, PPOs and HMOs tend to credential providers because these organizations are presumed to be at greater liability if one of their pre-designated providers possesses inadequate credentials. This greater liability stems from the fact that the PPO or HMO has required its members to access care from a pre-designated panel of providers.

Category One (General Managed Care Principles)

e. *Dispute Resolution*

Dispute resolution can be defined very broadly or very narrowly in MCOs. Both in health care and workers’ compensation MCOs, dispute resolution can be narrowly applied so as to include only a dispute resolution mechanism to address disputes that occur between the patient and the provider. Alternatively, the term can be so broad as to include a dispute resolution mechanism to address disputes between any participant or contractor that is involved in the care of the injured worker. Very often, before a member, provider or other participant in a managed care setting can litigate an issue, individual must first exhaust their rights and responsibilities under the MCO’s dispute resolution process.

Generally, MCOs classify disputes with either members or providers as less serious “complaints” or more serious “grievances”. These categories are often subcategorized as either “administrative” complaints and grievances, which generally involve issues surrounding the administration of the plan (e.g., excessive waiting times, inadequate facility access, etc.) or “clinical” complaints or grievances, which generally involve issues of a clinical nature (e.g., medical malpractice, designating of medical necessity, etc.) In addition, members of MCOs are allowed to participate in an Independent Medical Review (IMR) if they feel that an MCO has incorrectly denied medically necessary services (see Utilization Review section of this report for additional details on the California IMR process).

CATEGORY Two; KEY PRINCIPLES OF WORKERS’ COMPENSATION MCOs

As noted in the introductory section of this report, the workers’ compensation managed care concepts in Category One are general concepts that apply equally to managed health care systems as they do to

managed workers' compensation systems. In addition to these general concepts, there are three additional concepts that are more important to the overall effectiveness of a *workers' compensation* managed care system.⁸¹ These three principles are: the workers' compensation MCO certification processes (hereinafter "MCO certification"); utilization management processes including peer review and case management (hereinafter "UM") and quality management processes including quality assurance and quality improvement services (hereinafter "QM"). These three categories of managed care principles, and their sub-principles, are the core building blocks of a workers' compensation managed care system.

The importance of MCO certification, UM and QM in workers' compensation managed care does not imply that the general managed care principles noted above (integration, provider selection, etc.) are unimportant in workers' compensation. Rather, these general managed care principles are simply more generic principles that apply uniformly, with little modification, both in a managed health care setting and a managed workers' compensation setting. By comparison, MCO certification, UM and QM are the key concepts in a workers' compensation setting, and are most effective when they are changed from their application in a health care setting to fit the unique aspects of a managed care workers' compensation system.

To illustrate the various ways in which different workers' compensation jurisdictions address the three key issues of MCO certification, UM and QM, six states (Connecticut, Florida, Minnesota, New Hampshire, North Carolina and Oregon) were selected to illustrate the various ways in which these three key concepts are considered in other jurisdictions. Below is the state-to-state comparison of these three key workers' compensation managed care concepts.

Category Two; Key Principles of Workers' Compensation MCOs

f. *Workers' Compensation MCO Certification Requirements (Six State Comparison)*

In most states, the certification process sets forth the mandatory elements that a managed care organization must meet in order to treat injured workers.⁸² These elements most often include concepts that apply to managed care health plans, as well concepts that are designed specifically to meet the needs of injured workers. It is in the certification process that states attempt to assess whether the proposed managed care organization (MCO) is capable of delivering the needed structural, procedural and outcome elements necessary to address the specific, and sometimes unique, needs of a compensably injured worker.

It is essential that managed care workers' compensation programs have certification processes designed to address the unique aspects of a workers' compensation managed care system. A state certification process must ensure that these managed compensation programs will not provide basic health insurance benefits to injured workers as fundamental differences, such as the common presence of a disability in workers' compensation, that exist between the two systems. For instance, one fundamental difference that exists between managed care health coverage and workers' compensation coverage, managed care or otherwise, is the fact that states generally mandate employers to carry workers' compensation insurance. Health insurance, by contrast, is infrequently mandated and is often

⁸¹ These three concepts (MCO certification, UM and QM) are also key aspects of a health care managed care organization. However, to be effective in a workers' compensation setting they must be modified, from their pure health care context, to meet the unique needs of an injured worker. For instance, workers' compensation managed care case managers must contend with issues such as facilitating the injured worker's return to work, rather than just limiting the case management to medical matters.

⁸² In this report the phrase "injured workers" is used to refer to workers' who are eligible to receive compensation benefits, whether they are eligible to receive these benefits due to a compensable injury or disease.

a job “perk”⁸³ that is used to attract and retain high quality workers. As such, employers have an incentive to contract with a health care MCO that provides high quality care. In comparison, the quality of a workers’ compensation program (managed care or otherwise) is rarely a motivating factor in attracting and retaining employees, particularly given the highly regulated benefits that lend uniformity to workers’ compensation programs. Therefore, employers may be, at least partially, provided an incentive to pay less attention to the quality of the workers’ compensation services.

These differences between a health care MCO and a workers’ compensation MCO are compelling reasons why a state certification process must ensure that the unique needs of injured workers must be met. Substantive structural certification requirements to address the needs of managed care workers’ compensation programs include, but are not limited to, the development and implementation of utilization management, peer review, case management and quality management criteria that are uniquely tailored to meet the needs and requirements of the injured workers seeking care from the workers’ compensation MCO. The substantive procedural certification requirements include, but are not limited to, adequate processes for review by the certifying state agency of the workers’ compensation MCO certification requirements. The substantive outcome certification requirements include items such as return-to-work rates and general health outcome results for compensable injuries. To illustrate how various states, including California, address the unique structural and procedural aspects of workers’ compensation MCOs through their certification process, the certification processes of six states are summarized below.

In **California**, Section 4600.5(a) of the Labor Code allows any entity to apply to become a certified health care organization (HCO) to provide health care to compensably injured workers, including a Knox-Keene licensed HMO, a licensed disability insurer, a workers’ compensation insurer or a third party administrator authorized by the administrative director.

In summary, the administrative director will certify a licensed an HMO or disability insurer if the entity is in “good standing” with its licensing board (the Department of Managed Health Care (DMHC) for HMOs and the Department of Insurance (DOI) for disability insurers). The entity must also meet additional requirements, including providing a program to promote workplace health, safety and return to work, as well as providing all required medical and health care services and meeting all mandated reporting requirements (UR, cost, rates of return to work, financial solvency, DMHC, etc.). A certified HCO must also demonstrate the ability to provide occupational medicine and related disciplines and establishing a written grievance policy, among others requirements.

A workers’ compensation insurer, third party administrator (TPA) or other entity must also be certified by the administrative director. These entities must meet the basic requirements that are similar to those required of an HMO or disability insurer. In addition, a workers’ compensation insurer, TPA or other entity must operate on a fee-for-service basis, it cannot provide prepaid health care services and it cannot assume risk. The administrative director may also refuse to certify, or she may revoke or suspend the certification, if the entity’s plan to provide medical treatment fails, services are not being provided, or the entity loses its good standing with its licensing agency. Furthermore, certified entities that provide care to injured workers are also required to provide guidelines for, and access to, chiropractic and acupuncture care and integrate these forms of care into their grievance and utilization review procedures.

⁸³ Managed Care in Workers’ Compensation, Mark J. Brown, Ph.D., and Dan R. Anderson, Ph.D, CPCU (position paper submitted to NARPPS).

Beyond the requirements noted above, Section 4600.6 of the California Labor Code contains detailed requirements that any entity seeking certification as a health care organization (HCO) to provide care to injured workers must meet. In summary, the HCO applicant must submit the basic organizational legal documents of the application (bylaws, rules, regulations, etc.) a listing of the key members of the organization and primary shareholders, copies of provider contracts, a statement describing the organization, its method of providing health services, its physical facilities, its health care delivery capabilities, its collateral and advertising materials (disclosure forms, etc. which cannot be misleading, discriminatory or untrue), its financial statements, its methods of marketing, its service areas, its grievance processes, its internal systems for monitoring quality of care, its primary and reinsurance program, and any other information the administrative director may require. The HCO must also meet, in addition to multiple other requirements, licensing requirements, professional requirements (licensing, certification, etc.), staff minimums, minimum contractual requirements for care providers, quality of care and utilization requirements, among others. The above noted mandated requirements are monitored periodically by the administrative director through an onsite survey, with a mandated corrective action procedure for correcting deficiencies.

Chapter 4.5 (Division of Workers' Compensation), Subchapter of the California Code of Regulations provides additional details to supplement the Labor Code (as noted above) regarding the standards that must be met by an entity that is applying to become, or operating as, an HCO. For instance, Section 9772 requires applicant entities to demonstrate that they meet certain minimum requirements such as appropriate equipment and personnel licensure, utilization review and continuity of care requirements, access requirements, financial requirements, and contractual requirements.⁸⁴

In 2002, the California Legislature enacted AB 749, therein revising several important aspects of the rules under which an HCO may qualify under California law to offer workers' compensation services. Under AB 749, any health care service plan licensed pursuant to the Knox-Keene Health Care Service Plan Act (which licenses and regulates HMOs in California) or a disability insurer licensed by the Department of Insurance, or any entity, including, but not limited to, workers' compensation insurers and third-party administrators may apply to become certified as a health care organization (HCO) to provide health care to injured employees. Under this new law, if the HCO is licensed pursuant to the Knox-Keene Health Care Act, that organization shall be deemed to be an HCO able to provide health care without further application, assuming they maintain good standing with the Department of Managed Health Care (DMHC) and meet the following requirements⁸⁵:

- (1) Provide all required medical and health care services.
- (2) Provide a program involving efforts by employees, the employers, and the health plan to promote workplace health and safety, consultative and other services, and early return to work.
- (3) Propose a timely and accurate method to meet the requirements for all carriers of workers' compensation coverage to report necessary information regarding medical and health care service cost and utilization, rates of return to work, average time in medical treatment, and other measures necessary to determine the effectiveness of the plan.
- (4) Demonstrate the capability to provide occupational medicine and related disciplines.

⁸⁴ Chapter 4.5 (Division of Workers' Compensation), Subchapter 1, Article 4 (Certification Standards for Health Care Organizations) (specifically, Sections 9770 through 9779.9 of Chapter 4.5 encompass the complete listing of the regulations that support the Code with regard to the application of entities to become an HCO).

⁸⁵ In addition to the new certification requirements noted above, AB 749 provides additional changes to the way in which an HCO may qualify and treat a compensable injured worker. These additional changes include restricting coverage to a provider of the employee's choice (that is, a provider outside of the HCO system) only after 180 days after the accident as well as allowing an employer to offer a single HCO to employees.

(5) Complies with any other requirement the administrative director determines is necessary to provide medical services, including a establishing a written grievance policy.

In **Connecticut**, since 1992, any employer or insurer acting on behalf of an employer may establish a plan for the provision of workers' compensation managed care that is subject to the approval of the chair of the Connecticut Workers' Compensation Commission.⁸⁶ The prospective managed care plan is required to submit a listing of appropriately licensed and credentialed participating providers, access information (times, places and manners of access), a description of how the quality and quantity of care will be managed, as well as any further information desired by the employer and employees.

At least 120 days prior to the proposed effective date of the managed care services being rendered to injured workers, the prospective plan should submit the information noted above to the chair of the Commission for her approval. Approval is given by the Chair in consultation with a medical advisory panel that is appointed by the Chair. Such standards include the ability of the plan to provide timely, effective and convenient services to injured workers; the inclusion in the plan of an adequate breadth and number of physicians; the use of appropriate financial incentives to reduce costs and utilization without a reduction in quality of service; the inclusion of fee screening, peer review, service utilization review and dispute resolution procedures to prevent excessive treatment; and, a procedure to report on health care procedures and costs and utilization to the Chair to determine the effectiveness of the plan.

In **Oregon**, managed care organizations (MCOs) that provide health care services to injured workers' must be certified by the Oregon Department of Consumer and Business Services before they are allowed to provide managed care health benefits to injured workers. As of June 26, 2001, there are nine active and seven inactive MCOs in Oregon. Since October 30, 1991, Kaiser Foundation Health Plan (Kaiser-on-the-Job) has been a registered MCO in Oregon. In California, the Kaiser health plan of California also provides health benefits to injured workers, and is a registered Health Care Organization (HCO) in California. Two MCOs in Oregon have been voluntarily decertified.

The certification process in Oregon is a three-part process. First, the parties interested in becoming an MCO must post their Notice of Intent to create an MCO.⁸⁷ Second, the plan must demonstrate how they will comply with the detailed certification requirements that are contained in Section 436-015-0030 of the Oregon Code, which include items such as: access requirements, notice provisions that inform workers' of available MCO services, out-of-network coverage requirements, provisions for timely, effective and convenience-of-care standards, financial requirements, utilization review, peer review and dispute resolution requirements. The third step to become a certified MCO in Oregon requires the parties interested in becoming an MCO to submit a final application form, which includes the names and addresses of providers and the geographical service area (GSA) in which the MCO will operate. Lastly, they must pay a non-refundable fee of \$1,500. The Oregon Department of Consumer and Business Services Notification will issue, within forty-five days of receiving all required documentation, the effective date of certification and the GSAs in which the MCO is certified to operate.

The process in **Florida** to certify workers' compensation managed care arrangements (WCMCAs) is administered by the Agency for Health Care Administration (AHCA), while the Division of Workers' Compensation (DWC) ensures that injured workers receive timely and appropriate benefits and

⁸⁶ Section 31-279 (c) of the Connecticut Workers' Compensation Act (the "Act").

⁸⁷ This Notice of Intent is to make the public aware of the intent of the parties, thereby helping to avoid any antitrust violation when meeting to form the MCO.

services and certifies health care providers. These two agencies partner to oversee the administration of medical benefits to injured workers.

The AHCA authorizes an insurer to offer or utilize a workers' compensation managed care arrangement upon the payment of a fee (\$1,000.00) and completing an application to the satisfaction of the AHCA.⁸⁸ These application standards include the requirement that the quality of care that would be provided would be consistent with the prevailing professional standards of care, and otherwise meet the requirements of the statutes and rules that govern the administration of managed care workers' compensation benefits in Florida. The insurer must also file a proposed managed care plan of operation to demonstrate that all services are available and accessible, as well as a detailed demonstration of the key components of a managed care program for workers. These requirements include extensive details addressing all the key operational aspects of a managed care workers' compensation system, including the fact that workers must have access to services, that the number and breadth of providers in the managed care provider panel must be sufficient to render necessary care, that emergency care is always available, the service area, the grievance process, the quality assurance program, peer and utilization review standards, and a written statement of goals and objectives that stresses health and return-to-work outcomes. These are just a sampling of the key elements that are required to be present in the application to become a certified provider of managed care benefits for injured workers' in Florida.

In **Minnesota**, since December 1, 1993, the commissioner of the Minnesota Department of Labor and Industry may certify any person or entity, *other than a workers' compensation insurer or employer for its own employees*, as certified managed care plans. Section 173.1351 (Managed Care), Subdivision 2, of the Code of Minnesota (Minnesota Statutes 2000) outlines the minimum standards that a managed care entity must propose to become certified. Pursuant to Minnesota Rule 5218.0030, no person or entity shall present itself as a workers' compensation managed care plan without being so certified.

For example, in Minnesota, under the provisions of Subdivision 2, the plan must propose to provide "quality services" that meet uniform treatment guidelines, geographical convenience, financial services that reduce costs without sacrificing quality, peer and utilization review, dispute resolution processes, case management, method for reporting medical information to the commissioner, out-of-network care by a provider who has a documented history with the worker and who will refer back in network for additional services, and the right of the worker to switch providers at least once, among others.

Lastly, in Minnesota, the commissioner can revoke or suspend the certification of a managed care plan if she finds that the plan has failed to provide services that comport with the requirements of the above section. In lieu of a suspension or revocation, the commissioner can assess an administrative penalty of up to \$25,000.00 for each violation or incidence of noncompliance by the plan.⁸⁹

In **New Hampshire**, employers, their insurance carriers or self-insured employers are given the option of administering their obligation of providing health insurance services to their injured workers through a managed care plan that has been approved by the commissioner of the New Hampshire workers' compensation authority. The commissioner also has the authority to withdraw her approval of a managed care organization if she feels that organization has failed to meet its obligations under the New Hampshire workers' compensation managed care statutes. As is the common practice of most states that allow workers' compensation managed care services, the New Hampshire code notes that a

⁸⁸ Title XXXI, Chapter 440, Section 134 (2)(a) of the Florida Statutes (2000).

⁸⁹ Section 176.1351, Subdivision 5 (b) of the Code of Minnesota (Minnesota Statutes 2000).

managed care plan shall not be approved unless the commissioner finds that the proposed managed care plan meets certain minimal criteria. These minimal criteria include, but are not limited to, the establishment of a sufficiently comprehensive network in both specialty and location, the allowance for out-of-network referrals, credentialing requirements, case management and rehabilitation management, access to second medical opinions, dispute resolution services for the employer to resolve a conflict in medical opinions and the requirement that the managed care organization's staff of injury management facilitators, case managers and rehabilitation managers are located in New Hampshire.

New Hampshire has several unusual traits among the states reviewed with regard to the approval of a managed care organization. One of these unusual traits is the requirement that, in addition to the approval noted above by the commissioner, the approval of a managed care program shall require a ratification vote of the advisory council on workers' compensation, established under RSA 281-A:62.

A second unusual trait among the states considered in this paper is the fact that under New Hampshire workers' compensation law, a prospective managed care program is "deemed to have been approved by the commissioner unless, within 45 days after its filing with the commissioner, the commissioner makes a preliminary determination of noncompliance, specifying in writing the reasons why the program does not appear to conform to the [certification requirements detailed above]." In other words, inaction within forty-five days by the commissioner deems the proposed managed care organization as acceptable. In addition, the commissioner must submit her approval of a managed care organization to the advisory council for its approval within five days. Inaction by the advisory council within nineteen days also automatically renders their approval of the proposed managed care organization.

In **North Carolina**, the Department of Insurance (DOI), rather than the Industrial Commission of North Carolina, is the primary regulator of managed care organizations that treat workers' compensation patients.⁹⁰ As such, before either a Health Maintenance Organization (HMO) or a Preferred Provider Organization (PPO) can provide managed care medical benefits to compensably injured workers, the HMO or PPO (collectively abbreviated managed care organizations (MCOs)) must have a certificate issued by the North Carolina DOI.⁹¹ This requirement is reiterated in *The North Carolina Industrial Commission Rules for Managed Care Organizations*⁹². Pursuant to these rules, and prior to providing any services for workers' compensation patients under an MCO contract, an MCO must comply with the generally applicable MCO statutes⁹³ (non-workers' compensation specific) that apply to all MCOs, as regulated by the DOI. Under these general MCO requirements, an MCO supplying benefits for compensably injured workers must meet specific organizational requirements, including standards for health care provider contracts, access, finances, quality management, credentialing, conflict of interest, records and examinations, internal auditing and confidentiality.⁹⁴

In addition to this certification by the DOI, if the MCO is managing the care of the workers through processes that includes pre-authorization of services then the DOI must also issue a URO (Utilization Review Organization) Certificate to that MCO.^{95,96}

⁹⁰ Memorandum, *MCOs interested in care of WORKERS' COMPENSATION patients*, Commissioner J. Randolph Ward, North Carolina Industrial Commission, December 6, 1995.

⁹¹ N.C. Gen. Stat. §§ 97-2 (21) and 58-50-55.

⁹² Effective January 1, 1996,

⁹³ N.C. Gen. Stat. Chapter 58 (Insurance).

⁹⁴ *Id* (see also Rule III, *The North Carolina Industrial Commission Rules for Managed Care Organization*.)

⁹⁵ N.C. Gen. Stat. §§ 97-25.3 (e).

Category Two; Key Principles of Workers' Compensation MCOs

g. *Workers Compensation MCO Utilization Management Processes, Including Peer Review and Case Management (Six State Comparison)*

Utilization review (UR) is generally considered a key component of a managed care system, both in a workers' compensation and a traditional health care context. As one of the most common requirements for a certified managed care program,⁹⁷ UR programs are considered an integral part of a workers' compensation managed care program.⁹⁸

The phrase "utilization review" (used interchangeably with the term "utilization management") encompasses a variety of utilization control techniques that are intended to produce a more appropriate and cost efficient use of health care services. Thomas Chapman, in his article titled *Sources of the Medical Cost Problem and Implications for Managed Solutions*⁹⁹ defines utilization management as follows.

... utilization management really consists of a variety of types of utilization review. Inpatient utilization review (which includes preadmission, concurrent review, and discharge planning), physical therapy review, chiropractic review, psych and substance review, physician peer review, preauthorization of certain surgical and diagnostic procedures, and so on – all of these different types of review collectively represent utilization management. They all have their own clinical criteria, etc. and are highly specialized. These services are controls to attach the problem of overutilization.¹⁰⁰

By utilizing care in the most appropriate fashion, and specifically addressing the problem of over-utilization, the expected result will be better care at a lower cost. However, UR programs can address discrepancies in care other than over-utilization, such as lowering the costs due to unnecessary care, and variations in surgical and hospital admission rates.¹⁰¹ Studies of UR programs in a general health care context reduced hospitalizations between 10% and 15%, and reduced total health care expenditures by 6%,¹⁰² with a proportional decrease in the cost of care. However, the reduction in the utilization rates, and the accompanying cost savings in a workers' compensation context, have not been studied as extensively.¹⁰³ In 1999, Wickezer, et al, studied the effect of 11,785 utilization management

⁹⁶ Prior to the Reform Act in North Carolina, the use of preauthorizations as a tool to manage the utilization of care was prohibited. However, with the enactment of 97-25.3, an MCO is authorized to request a preauthorization or precertification requirement for certain inpatient admissions to a hospital or treatment center, as well as inpatient or outpatient surgery. However, if the MCO has been designated a utilization review organization (URO) by the department of insurance, preauthorization may be allowed more extensively.

⁹⁷ *Managed Care and Medical Cost Containment in Workers' Compensation, A National Inventory, 1998 – 1999* WC-98-7, Workers' Compensation Research Institute, Ramona P. Tanabe, at 70.

⁹⁸ Tanabe at 72.

⁹⁹ Thomas Chapman, *Sources of the Medical Cost Problem and Implications for Managed Solutions*, a chapter appearing in *Review, Regulate, or Reform? What Works to Control Workers' Compensation Medical Costs*, Workers' Compensation Research Institute, Thomas W. Grannemann, Editor 1994.

¹⁰⁰ Although this quote refers to over-utilization of services, UR is not limited in scope to only reducing over-utilization. Rather, it is also applied to address *underutilization* of services (which a common lament of managed care systems) by ensuring that members receive all the care that they need from an appropriate provider.

¹⁰¹ Controlling Workers' Compensation Medical Care Use and Costs Through Utilization Management, *Journal of Occupational and Environmental Medicine*, Thomas Wickizer, Daniel Lessler and Gary Franklin, August, 1999, Volume 41, No. 8, at 625.

¹⁰² *Id.*

¹⁰³ Wickizer, et al at 625.

reviews in a workers' compensation context for both inpatient and outpatient care. This study, which is limited in its conclusions to its study population, revealed that the utilization management reviews that resulted in substantial cost savings and decreasing inpatient length-of-stay duration were concentrated in a relatively small number of procedures.¹⁰⁴

In 1993, the State of Washington initiated a Managed Care Pilot (MCP) project to assess the effects of providing injured workers with health care services under a managed care arrangement (capitated payment) as compared to workers who were treated under a traditional fee-for-service (non-capitated payment) arrangement.¹⁰⁵ While health outcomes were not substantially different, medical costs were significantly lower (on average 22% lower) in the managed care population. In addition, the ratio of injured workers receiving time-loss (disability) payments in the managed care group (14.7%) was significantly lower than the ratio of injured workers receiving time-loss (disability) payments in the fee-for-service group (19.2%).¹⁰⁶

Further evidence of cost cutting from the use of managed care techniques is presented from a longitudinal study of two cohorts that examined the cost savings that were realized after instituting a managed care program (a PPO) that included on-site case management and proactive safety engineering and ergonomic controls.¹⁰⁷ The costs compared between the two cohorts reflected a 50% overall reduction in total expenditures and a 62% overall reduction in compensation expenditures.¹⁰⁸ These dramatic cost savings were provided where quality of care did not appear to be lowered (though this study did not specifically examine quality of care issues directly) in a managed care setting that emphasized ergonomic and safety issues.¹⁰⁹

Utilization of services (breadth and frequency of services) in a traditional, fee-for-service health care delivery system, whether for the provision of workers' compensation medical benefits or for basic health care services, is primarily controlled by the patient. Within reason, the fee-for-service patient dictates the selection of her providers (both primary care and specialists), the frequency of care, the mode of care, the location of hospital and ancillary service providers, the selection of subacute care, as well as many other aspects of her health care. The fee-for-service patient may receive guidance and advice from her health care providers as she traverses through the health care system, but many of the fundamental decisions surrounding her care are her own.

The above information notwithstanding, even in a traditional fee-for-service delivery system (workers' compensation or general health care), the patient is not at liberty to seek *all* care from *any* provider. Utilization management (UM) and utilization review (UR) tools are present in the context of a fee-for-service system, despite that fact that these concepts are more commonly associated with a managed care system. Examples of a limit on utilization of services in a fee-for-service system include the

¹⁰⁴ Wickizer, et al at 630.

¹⁰⁵ Improving the Quality of Workers' Compensation Health Care Delivery: The Washington State Occupational Health Services Project, Thomas M. Wickizer, Gary Franklin, Roy Plaeger-Brockway and Robert D. Mootz, *The Milbank Quarterly*, Volume 79, No. 1, 2001.

¹⁰⁶ Wickizer, et al, at 13. However, it should be noted that patient satisfaction was lower in the managed care group than the fee-for-service group, the lower satisfaction rate primarily being due to access to care (Id at 14).

¹⁰⁷ Comparison of Workers' Compensation Costs for Two Cohorts of Injured Workers Before and After the Introduction of Managed Care, Judith Green-McKenzie, John Parkerson and Edward Bernacki, *Journal of Occupational and Environmental Medicine*, June 1998, Volume 40, No. 6, at 568. (see also *The Effect of Managed Care on Surgical Rates Among Individuals Filing for Workers' Compensation*, Edward J. Bernacki, Jill A. Guidera, *Journal of Occupational and Environmental Medicine*, Volume 40, Number 7, page 623 (July 1998)).

¹⁰⁸ Id.

¹⁰⁹ Id at 570-1.

restriction that to be a covered benefit the care sought by the patient must be, as a general rule, deemed “medically necessary,” and not experimental, investigational, cosmetic or otherwise excluded as a covered benefit.¹¹⁰ In addition, even traditional fee-for-service plans often will require some pre-authorization for specific procedures before their members are able to access care. The types of procedures that require pre-authorization are typically expensive surgical procedures, in-patient admission to hospitals or surgery centers or other expensive types of health care services.

Similarly, workers’ using a fee-for-service system are also often restricted by utilization review (UR) techniques (despite the fact that utilization review is more commonly associated with a managed care setting than a fee-for-service setting) to help lower costs by lowering utilization.¹¹¹ For instance, “workers’ compensation statutes may prohibit, authorize, encourage or mandate utilization review” and “[i]ncreasingly, jurisdictions have mandated that payers must provide UR services within and outside of managed care arrangements.”^{112 113} The types of utilization tools and techniques for compensably injured workers in a fee-for-service workers’ compensation context are similar to those required for those in a fee-for-service health care context. These UR techniques traditionally have included determinations of medical necessity, appropriateness of the services, length of stay (LOS) for hospital in-patient admissions and specialist consultations¹¹⁴ and other high cost services and procedures.¹¹⁵ UR techniques in a FFS workers’ compensation system are now being applied to less costly services such as outpatient procedures and services.¹¹⁶ The use of UR standards in workers’ compensation can be state mandated or at the discretion of private workers’ compensation carriers imposing their own systems of UR for compensably injured workers.¹¹⁷

Cost savings through lower utilization rates is a key component of MCOs in workers’ compensation and general medical care. However, fundamental differences between the health care needs in a workers’ compensation context and a health care context do not allow some utilization review tools to be applied as effectively to injured workers. For instance, “preauthorization” of certain procedures is a common general health care utilization management tool. However, emergency claims (which are generally not preauthorized) are a very common claim in a workers’ compensation context so this tool

¹¹⁰ The above noted limitations on the utilization of care in a fee-for-service context are applied even more narrowly in a workers’ compensation context where the compensation carrier, or self-insured employer, is responsible for only the care that is causally related to, or the natural sequelae of, the compensable injury or disease. Should the claimant in a fee-for-service workers’ compensation context seek care that is determined not be medically necessary, or not causally related to the compensable injury or disease, that utilization of care will not be covered by the workers’ compensation fee-for-service carrier. In addition, the workers’ compensation regulations in multiple states require that once a worker is injured and begins to seek care from a particular health care provider, that provider becomes the coordinator of the care for the compensable injury or disease. In a workers’ compensation context, the utilization of medical care that is reimbursed on a fee-for-service basis is also commonly limited by presenting a “panel” of physicians from which the injured worker may choose a treating physician. Thus, a patient in a fee-for-service health care delivery system, particularly in a workers’ compensation context, is not given free reign to seek all health care without utilization limits by the carrier or self-insured employer.

¹¹¹ Tanabe at 72.

¹¹² *Id.*

¹¹³ The California Division of Workers’ Compensation also promulgates Utilization Review Standards (California Labor Code Section 139).

¹¹⁴ *Id.*

¹¹⁵ *Id.*

¹¹⁶ *Id.*

¹¹⁷ *Id.* at 72 (includes a table summarizing the type of utilization review/management programs thirty-five workers’ compensation jurisdictions)

is not as useful for managing the care of injured workers.¹¹⁸ Other utilization tools, however, are useful in the workers' compensation context, as well. For instance, hospitalization rates for workers with a particular type of back injury who were subject to non-emergent preauthorization requirements had "significantly fewer admissions than did workers with no preauthorization requirements."¹¹⁹ Lowering the utilization rates, whether by the application of preauthorization requirements or the use of standardized treatment protocols, results in cost savings.

As the presence of HMOs grows so does the use of UR process to manage services and lower health care costs, both in the workers' compensation and basic health care arenas.¹²⁰ To address this increased use of UR processes by MCOs, forty-four states¹²¹ have enacted legislation to give managed care enrollees the option to seek independent medical review (IMR) of utilization review decisions by the MCO, most commonly when authorization for care is sought and that authorization is either denied or modified by the MCO. IMR is an independent, medical case review of a health plan coverage denial based upon lack of medical necessity or the experimental nature of the proposed treatment. In California, the most commonly cited rationale for the legislation that created the IMR in California was to give MCO enrollees an independent reviewer of utilization decisions to help curb the incentive created by MCOs to restrict or deny care.¹²² The independence of review is achieved through the use of qualified medical experts not affiliated with the MCO (or sometimes the indemnity insurer, as well). A member whose request for an authorization has been denied or modified may request external review of such denials by an Independent Review Organization (IRO). This request for an IMR is usually requested after the member has exhausted MCO's internal grievance process (unless, in some states, the case involves an imminent threat to the member's well being).

The California Department of Managed Health Care (DMHC) administers the IMR process for California's Knox-Keene licensed HMOs (which may apply for HCO status to provide managed care benefits to injured workers). The Knox-Keene Act allows IMRs for utilization decisions by an HMO that the care sought by the member was not medically necessary, was experimental or investigational or that the member sought emergent or urgent care unnecessarily.¹²³ As noted above, the majority of other states have enacted some degree of external review to help oversee the utilization management decisions, often applying to both MCOs as well as traditional FFS insurance entities as well. Multiple states generate reports that summarize the pertinent facts of the external reviews (the number of reviews, the subject matter of the reviews, the results of the review, etc.) that were decided by their external review organization. While these reports often indicate who won the review of the health plan's utilization management decision (the consumer or the health plan), these reports generally do

¹¹⁸ Peele at 10 (citing to 4 *Quality Assurance, Utilization Review* (4):101-7, Grable HR. 1989. The effect of precertification on the rate of hospitalization of patients with low back pain: a case study comparing hospitalization rates of patients covered by workers' compensation and no-fault automobile insurance in New York State.)

¹¹⁹ Id.

¹²⁰ Utilization Review in California's Workers' Compensation System, A Preliminary Assessment, July 2001, Linda Rudolph, MD, MPH (citing to Independent External Review in 2001, State by State Guide to Managed Care Law, Levy D., Editor 2001, Aspen Publishing.)

¹²¹ For instance, the six states highlighted in this report (Connecticut, Florida, Minnesota, New Hampshire, North Carolina and Oregon) all have External Review laws (alternatively referred to in various jurisdictions as Independent Medical Review, External Appeals, Independent Appeals or External Reviews) (e.g., see Conn. Gen. Stat. Ann. Section 38a-478n (West Supp. 2001); Fla. Stat. Ann. Section 408.7056 (West Supp. 2001); and N.H. Rev. Stat. Ann. Section 420-J:5-a (2000)).

¹²² UCLA Law Review, Shirley Eiko Sanematsu, Volume 48, No. 5, June 2001 at 1263.

¹²³ Section 1370.4 of the Knox-Keene Act describes how an enrollee can request an IMR of determinations by an HMO that the care requested is investigational and experimental. As of January 1, 2001, sections 1374.30 through 1374.36 establish the IMR process for the DMHC, as well as the requirements for reviews of medical necessity.

not reflect whether the quality of the care was improved.¹²⁴ The New York Department of Insurance, for instance, has generated its first *External Appeal Program Annual Report* (for the period of July 1, 1999 through June 30, 2000) that reflects, among other information, the types of external appeals, the rate of reversal of the health plans decisions and the cost of the appeals.¹²⁵ The California Department of Managed Health Care (DMHC) publishes an updated summary, by month through October 2001, of the total number of grievances submitted the California DMHC IMR program (472), as well as the number of HMO utilization review decisions upheld by the IMR panel (279), the number of decisions that were reversed by the IMR physicians (158) and the number of decisions reversed by the HMO while the IMR was pending (35).

As noted above, one of the common¹²⁶ components in a workers' compensation managed care system is the development and implementation of a utilization management (UM) program, including utilization review (UR), peer review (PR) and case management (CM) processes. Indeed, one of the fundamental components to a managed care system, if not *the* fundamental component, is the management of care by the MCO through UR, PR and CM. As such, many states' managed care workers' compensation programs address these processes statutorily. Some workers' compensation managed care systems utilize a UR program with predetermined guidelines that are codified "best practices" for a wide variety of injuries or diseases. The practice of certifying guidelines to address common worker ailments has been embraced by several states, including Massachusetts, Washington, West Virginia and Oklahoma. Following a diagnosis, physicians may use these published guidelines or protocols to help guide the health care services rendered to the injured worker. Other states address the key principle of Utilization Management in a workers' compensation managed care system by mandating simply that UM processes must be integrated into the managed care program to promote efficient and cost effective care. An effective UM program in a workers' compensation managed care context can result in a more medically appropriate utilization of medical care in a workers' compensation context. The effectiveness of utilization programs was demonstrated in a 1996 study, in which EJ Barnacki and SP Tsai of the Johns Hopkins School of Medicine describe a their evaluation of three years of workers' compensation claims in a workers' compensation PPO, *Managed Care for Workers' Compensation: Three Years of Experience in an "Employee Choice" State*.¹²⁷ The authors of this study conclude that environmental risk management and care management in this PPO resulted in significant declines in utilization rates.¹²⁸

In **California**, Section 4600.6 (k) of the Labor Code requires that every health care organization (HCO) that provides managed health care services to injured workers must "establish procedures in accordance with the regulations of the administrative director for continuously reviewing, among other processes, the utilization of services and facilities, and costs." Section 9773 of Chapter 4.5 (Division of Workers' Compensation) of the California Code of Regulations requires that HCOs must provide injured workers with access to all reasonable medical, surgical, chiropractic and hospital care. Section

¹²⁴ Although, quality of care assessments are generally not specifically cited, if the member receives care that is determined to be medically necessary (at least through the eyes of the external review organization) that member presumably received a higher quality of care that would have been rendered without the external review.

¹²⁵ One of the most established external appeal organizations in the United States is the one conducted by the Center for Health Dispute Resolution (CHDR) that is contracted with the Center for Medicaid and Medicare (formerly HCFA) to provide external appeals for managed care Medicare beneficiaries.

¹²⁶ Managed Care and Medical Cost Containment in Workers' Compensation, A National Inventory, 1998-1999, Workers' Compensation Research Institute WC-98-7, Romona P. Tanabe, at 70.

¹²⁷ *Managed Care for Workers' Compensation: Three Years of Experience in an "Employee Choice" State*, Journal of Occupational Environmental Medicine, November 1996, Volume 38, pages 1091-7.

¹²⁸ *Id.*

9774 requires that the HCO establish a program that reviews the medical reasonableness or medical necessity of requests from providers as well as the answers to those requests from the HCO. The HCO must describe the specific criteria utilized in the review and decision making processes, and the treatment protocols must be consistent with those outlined in the California Labor Code. The qualifications of the personnel involved in authorizing, and the manner in which they are involved in the authorization, must also be described.

In **Connecticut**, Section 31-279 of the Workers' Compensation Act requires that when a prospective plan is applying to be approved as a provider of workers' compensation managed care benefits, that plan must submit to the Chair of the Connecticut Workers' Compensation Commission an application that includes, among many other components, "fee screening, peer review, service utilization review and dispute resolution procedures designed to prevent inappropriate or excessive treatment." Presumably, the term "inappropriate" includes the prevention of underutilization of services (as opposed to excessive treatment), which is generally a bigger concern in a managed care setting, as the capitated payment structure potentially creates an incentive to under-prescribe and/or under-treat.¹²⁹

Section 31-279-10 of the Administrative Regulations for the Connecticut Workers' Compensation Act includes the requirement that the plan include in its submission to the Workers' Compensation Commission a "written description of the plan's review and appeal procedures for service utilization review and dispute resolution..." Subsection (e) of 31-279-10 requires that each medical plan shall include provisions for utilization review and a method to evaluate the necessity and appropriateness of recommended medical and health services, as well as details of the dispute resolution process should a request, under the utilization review program, be denied for particular care. The review procedures of the utilization review process must meet multiple requirements, including, but not limited to, requirements for timeliness, use of clinical criteria and the reviewers' licensure and credentials.

In **Oregon**, the workers' compensation statute regulating managed care provides that "[s]ervice utilization review means evaluation and determination of the reasonableness, necessity and appropriateness of a worker's use of medical care resources and the provision of any needed assistance to clinician or member, or both, to ensure appropriate use of resources. 'Service utilization review' includes prior authorization, concurrent review, retrospective review, discharge planning and case management activities." In Oregon, the workers' compensation managed care statutes also provide directly that in the application to become a certified MCO, that prospective MCO must provide adequate methods of service *utilization review or peer review* (among other methods of review) "to ensure appropriate treatment or to prevent inappropriate or excessive treatment, to exclude from participation in the plan those individuals who violate these treatment standards and to provide for the resolution of such medical disputes as the director considers appropriate. A majority of the members of each peer review, quality assurance, service utilization and contract review committee shall be physicians licensed to practice medicine by the Board of Medical Examiners." (emphasis added)

In **Florida**, the utilization, peer review and care coordination criteria are imbedded in the statutory language that delineates the requirements in eleven separate, but related, sections for developing a

¹²⁹ Such an incentive to under-treat or under-prescribe in a managed care context is a function of the fact that reimbursement in a managed care environment is often via a capitation payment where all services are paid prospectively (usually on a per member, per month basis) for the care that is to be rendered, thereby creating a need to provide care that costs less than the monthly amount of capitation. The capitation payment can include reimbursement for all care that the member might need (e.g., hospital care, pharmaceutical care, ambulatory care, etc.) or it can include only limited care (e.g., ambulatory care only) with the remaining reimbursement to be paid on a fee-for-service basis or other reimbursement method.

“quality assurance program,” although the utilization and peer review requirements are laid out in the statute separately.

Section four (of the above noted eleven sections of a quality assurance program) requires that the workers’ compensation managed care insurer must provide, in its application materials for certification, a “written plan, which includes ongoing review, for providing review of physicians and other licensed medial providers.” Presumably, this standard requires that such “ongoing review” will include a review of the utilization patterns of physicians and other providers for both overutilization and underutilization of services. Section Six (of the above noted eleven sections) requires that the plan must contain “[a]dequate methods of peer review and utilization review. The utilization review process shall include a health care facilities precertification mechanism, including, but not limited to, all elective admissions and nonemergency surgeries.”

Lastly, Section Eight requires that as part of the certification process the insurer must demonstrate the process for “aggressive medical care coordination.” This requirement of care coordination mirrors that which many managed care health care organizations traditionally utilize. However, the Florida statute further requires an element that is unique to managed care in the workers’ compensation context by requiring “a program involving cooperating efforts by the workers, the employer, and the workers’ compensation managed care arrangement to promote early *return to work* for injured workers.” (emphasis added)

In **Minnesota**, utilization review, peer review and case management minimum standards are contained in the required processes that must minimally be met by an entity or person who is seeking certification to provide workers’ compensation managed care benefits. For instance, Subdivision 1, Subsection 4, provides that the proposed plan must provide “adequate methods of peer review, utilization review, and dispute resolution to prevent inappropriate, excessive, or not medically necessary treatment...” Rule 5218.0750, Subpart 2, requires that the plan must implement a utilization review program that must include the collection, review, and analysis of group data to “improve overall quality of care and efficient use of resources.” Subpart 2 additionally requires that the plan must specify which utilization data it will collect to analyze as part of its utilization review programs, as well as the methodology by which that data will be analyzed and how those results will improve care and increase the cost effectiveness of treatment.

Subsection 6 outlines the requirements for case management services that must be provided to workers. This section requires that the proposed plan implement and provide “aggressive case management for injured workers and provides a program for early return to work and cooperative efforts by the workers, the employer, and the managed care plan to promote workplace health and safety consultative and other services.” Rule 5218.0750, Subpart 1, requires that the plan must implement a peer review system to improve patient care and the cost effectiveness of treatment.

Rule 5218.0760 also requires that workers’ compensation managed care plans must provide “medical case management” to compensably injured workers. The role of the medical case manager is to “monitor, evaluate, and coordinate the delivery of quality, cost effective medical treatment, and other health services needed by an injured employee, and must promote an appropriate, prompt return to work. Medical care managers must facilitate communication between the employee, employer, insurer, health care provider, managed care plan, and any assigned qualified rehabilitation consultant to achieve these goals. The managed care plan must describe in its application for certification how injured employees will be selected for case management, the services to be provided, and who will provide the care.”

In **New Hampshire**, the statute giving authority to the commissioner of the New Hampshire workers' compensation authority to approve managed care programs includes the generally stated requirement that workers' compensation managed care programs must have "both inpatient and outpatient case management and rehabilitation case management." However, New Hampshire also requires that such organizations utilize "injury management facilitators" which is clearly a requirement designed to go beyond the traditional utilization review and case management functions of a health care managed care organization. The injury management facilitator effectively raises the level of integration and coordination between the right of the worker to receive appropriate medical care and the desire to return that worker to gainful employment. The New Hampshire injury management facilitator statute seeks to take full use of the strengths of care and case management that are the hallmarks of a managed care organization and combines them with key workers' compensation principles such a vocational rehabilitation, modified duty, and return to work programs. The detail of the New Hampshire injury management facilitator statute that contains these details is as follows:

Every managed care program shall include a sufficient number of injury management facilitators, including resident injury management facilitators, who shall be qualified by reason of education, training and experience to manage the injured employee's medical, hospital and remedial care, vocational rehabilitation, modified duty, and return to work plans. An injury management facilitator shall work with the injured employee, employer, and medical, hospital and other providers to ensure that the injured employee receives effective, timely, and appropriate services in order to achieve maximum medical improvement and an expeditious return to work. Any person employed as an injury management facilitator by a managed care program shall be approved by the commissioner with ratification by the workers' compensation advisory council. The commissioner shall, in consultation with the advisory council, by rule determine the number of facilitators which shall be sufficient.¹³⁰

In **North Carolina**, the concept of preauthorization for care, which is a significant component of a utilization management program, was not endorsed in the workers' compensation context until the North Carolina workers' compensation system was reformed in the early 1990s. However, with the reform act in place, and with the prevalence of managed care organizations (MCOs) growing, the use of preauthorizations became a codified form of utilization control in N.C. Code Section 97-25.2.¹³¹

Under Section 97-25.2 (a), an insurer may require preauthorization for inpatient admission to a treatment center, inpatient center or outpatient center. However, this law also codifies limitations on the preauthorization. These limitations include, for example, a maximum of ten days notice of the inpatient admission or surgery, and a maximum of two days turn-around time for responding to the preauthorization. In addition, the insurer may request an independent medical examination (IME) within seven days, and the insurer must provide that care if the IME physician concurs with the treating physician. A physician who is "on notice" of the preauthorization requirement can receive up to a fifty percent decrease in reimbursement if that physician failed to obtain a timely preauthorization. As a final "catch all" requirement for utilization management, Section 97-25.2 (7) (e) authorizes that

¹³⁰ Title XXIII, Section 281-A:23-a (V).

¹³¹ N.C. Gen. Stat. § 97-25.2.

an MCO may impose additional preauthorization requirements when providing care to workers' compensation beneficiaries as are appropriate under Chapter 58 (Insurance) of the North Carolina Code.

In North Carolina, the Industrial Commission of North Carolina is given the authority to adopt utilization rules and guidelines, both for medical and *rehabilitation services*. These additional rules and guidelines may include, but are not limited to, necessary palliative care, physical therapy treatment, psychological therapy, physiological help, chiropractic services, medical rehabilitation services and attendant care. Lastly, North Carolina specifically is authorized by the legislature to adopt utilization rules and guidelines for vocational and other rehabilitation.¹³²

Category Two; Key Principles of Workers' Compensation MCOs

h. Workers' Compensation MCO Quality Services (Six State Comparison)

Generally, quality management services¹³³ in a managed care setting can include "quality assurance" services, which seek to establish a system to assure that patients are given high quality medical services as well as "quality improvement services" to improve the quality of services provided to members. In any managed care situation, an established quality program is the cornerstone to providing high quality care.¹³⁴ In the workers' compensation managed care setting, the general term "quality management" embraces a wide variety of quality services that can be provided to injured workers, all of which are intended to provide quality health care and medical services for compensable injuries.

Fundamentally, MCO quality management programs seek to ensure that the MCO's services meet a professionally recognized standard of care. However, it should not be presumed that raising the quality of services provided by an MCO, whether in a workers' compensation context or a general health care context, automatically increases the overall cost of the services provided by the MCO. While a quality assurance/quality improvement process may require additional administrative costs for both the MCO and the provider, many processes that increase the quality of services may also lower the costs of care. For example, in a workers' compensation context it is imperative that the MCO provide a system of high quality care (by ensuring access to high quality providers who render high quality services) to help return an injured worker to her pre-injury employment as soon as possible, thus lowering the costs associated with replacement wages and protracted health care expenses. Additionally, quality management programs utilize quality measurement tools, such as satisfaction surveys (both member and provider satisfaction) to gauge the perceived level of care rendered by the MCO, thereby improving employer/employee relations and facilitating a higher return to work rate.

In **California**, Chapter 4.5 (Division of Workers' Compensation), Subchapter 1, Article 4, Section 9774 of the California Code of Regulations contains the minimum quality of care requirements for a certified HCO. The HCO must provide a "written program designed to ensure a level of care for occupational injuries and illnesses which meets professional recognized standards of care." The plan must have a process to identify problems and a process for correcting those problems, and it must describe the goals and objectives of the program and its organizational arrangements (staffing, methodology for monitoring, evaluation of health services, and the scope of the program). The quality

¹³² N.C. Gen. Stat. § 97-25.5.

¹³³ Quality management services also embrace services that are traditionally categorized under "quality assurance services", "quality improvement services", and the like. For the purposes of this paper, this variety of quality-orientated terms is considered under the general term "quality management services."

¹³⁴ Managed Care and Medical Cost Containment in Workers' Compensation, A National Inventory, 1998-1999, Workers' Compensation Research Institute WC-98-7, Romona P. Tanabe, at 71.

program must include a detailed assessment of the utilization of services, including a review of the processes used to make authorization decisions.

Section 9774 also prescribes that the HCO's quality assurance committee meet on at least a quarterly basis to oversee its quality assurance program responsibilities, and physicians (specialist and primary care) must be an integral part of the design and implementation of the program as well as its ongoing function. The quality assurance committee must report to the HCO's governing body in a way that identifies both the findings and actions of the committee, as well as significant or chronic quality of care issues. The quality program also must monitor the care provided by each contracting group or facility, or provide oversight of delegated quality assurance functions. The HCO must ensure that all comprehensive medico-legal reports are objective, fair and unbiased, the HCO must retain copies of all such reports for at least three years, and these reports must be available to the administrative director upon request. Lastly, the HCO must describe its activities for assuring data quality.

Under the **Connecticut** workers' compensation system, neither the Workers' Compensation Act nor the accompanying regulations detail the requirements of a quality of care system for injured workers who receive their medical care under a managed care system. However, Section 31-279 of the Workers' Compensation Act does require that a prospective workers' compensation managed care plan submit, in its application to the Commission to be a purveyor of workers' compensation managed care medical benefits, a "provision in the plan for appropriate financial incentives to reduce service costs and utilization *without a reduction in the quality of service*." (emphasis added) Although there are no further direct references to quality management services in the Connecticut workers' compensation act, there are several references to criteria that the managed care plan must meet that either directly or indirectly affect the quality of medical care provided to an injured worker in Connecticut. For example, Section 31-279-10 (5) (A) specifically notes that the list of providers must include "at least one occupational health clinic, auxiliary occupational health clinic or hospital that has a Board Eligible or Board Certified Occupational Health Physician." In addition, Section 31-279-10 (5) (B) outlines, in great detail, the many of types of providers, by specialty, that must be included to treat injured workers, including physical medicine and rehabilitation providers.

Under the **Oregon** workers' compensation MCO system, "quality assurance" is defined as "activities to safeguard or improve the quality of medical care by assessing the quality of care or service and taking action to improve it." To be certified as an MCO for injured workers in Oregon, the MCO must demonstrate to the Director (Director) of the Oregon Department of Consumer and Business Services that the MCO will comply with, among other criteria, certain criteria established by the Director for quality, continuity of care and other treatment standards in a way that is timely, effective and convenient for the worker. The Oregon statute includes also the requirement that the MCO provide adequate methods of quality assurance services, including the use of quality committees. Lastly, if a worker, insurer, self-insured employer, attending physician or other person is dissatisfied with (among other activities) the quality assurance activities of an MCO, the dissatisfied party can request a review of that activity by the director of the Oregon Department of Consumer and Business Services.¹³⁵

Though not categorized literally as "quality" criteria by the various workers' compensation managed care statutes, many states require their MCOs to meet additional conditions that are key elements necessary to ensure that high quality services are provided to the injured workers. For example, in Oregon, the workers' compensation MCO is also required not to exclude from the MCO panel of physicians any general category of physicians. This requirement also mandates that an adequate

¹³⁵ Section 656.260 (14) and 656.260 (17).

number of each category of medical service providers be listed as needed to treat injured workers. At a minimum, states that have enacted legislated parameters to their workers' compensation managed care programs have a general statement in their certification language that the panel of physicians offered under a workers' compensation managed care program must be adequate to treat the gamut of injuries traditionally sustained by workers.

In **Florida**, the certification requirements to provide workers' compensation managed care services include the general statement that an organization will not be certified to provide managed care services to injured workers unless it has adequately demonstrated to the Agency for Health Care Administration (AHCA)¹³⁶ that the "applicant has the ability to provide *quality of care* consistent with the prevailing professional standards of care..." (emphasis added) In addition, the certification requirements in Florida require that prospective managed care applicants must submit a proposed "managed care plan of operation" that includes, among other items, a description of the quality assurance program." This quality assurance program must assure that the services to workers are rendered under "reasonable standards of care consistent with the prevailing standards of medical practice in the medical community."¹³⁷ Within this comprehensive quality program, there must be eleven different aspects of quality of care, many of which mirror those included in a traditional health care managed care quality program. These include care monitoring, procedures for inappropriate or substandard services, review of the care provided by physicians, and others. The Florida statute, however, includes aspects of a quality program that are unique to workers' compensation including a statement of "goals and objectives that stresses health and *return-to-work* outcomes as the principal criteria for the evaluation of the quality of care rendered to injured workers." (emphasis added)

In **Minnesota**, a person or entity who is applying to become a certified managed care plan, other than a workers' compensation insurer or employer for its own employees, must propose to "provide quality of services that meet uniform treatment standards prescribed by the commissioner and all medical and health care services that may be required by this chapter in a manner that is timely, effective, and convenient for the workers." Although Minnesota workers' compensation managed care plans seek, like all such plans, to reduce service costs and utilization, Minnesota specifically states that those desired reductions should be accomplished "without sacrificing the quality of service."

In **New Hampshire**, Title XXIII, Section 281-A23-a (Managed Care Programs) of the workers' compensation laws only minimally considers the concept of quality management for their injured workers who are injured on the job. Section (1)(d) notes simply that the "program provides for acceptable quality assurance measures." There is no other direct reference in the New Hampshire workers' compensation statutes to detail the substance of these quality assurance measures, how they are to be monitored, or how they integrate into the remainder to the quality management program.

In **North Carolina**, Rule IX of the *North Carolina Industrial Commission Rules for Managed Care Organizations*¹³⁸ specifically requires that an "MCO subject to these rules shall comply with the requirements of the North Carolina Department of Insurance for *quality assurance* and utilization review plans, and upon request, provide the [North Carolina Industrial Commission] with copies of records generated by, or utilized in, the operation of those programs, and copies of plans or amendments to plans not yet filed with the Department of Insurance." However, as noted in the

¹³⁶ The Agency for Health Care Administration (AHCA) is the state agency in Florida that grants certification to organizations to provide workers' compensation managed care services.

¹³⁷ Title XXXI, Chapter 440, Section 134 (6)(C) (1 – 11) of the Florida Statutes (2000).

¹³⁸ Effective January 1, 1996.

Certification section of this paper, *supra*, the primary regulator and overseer of MCOs that provide benefits to injured workers in North Carolina is the Department of Insurance (DOI), which regulates all MCOs, workers' compensation and otherwise. As such, the DOI issues the majority of rules concerning quality of care, and the Commission issues few rules or regulations directly regulating quality issues or concerns in the workers' compensation context.

III. PHARMACEUTICAL SERVICES IN MANAGED CARE ORGANIZATIONS (General Discussion and Key Literature References)

Although pharmacy costs are, on average, less than ten percent of our national health care expenditures, the percentage of pharmaceutical costs is increasing at a high rate. This increase is anticipated to continue in the coming years.¹³⁹ In year 2000 it is estimated that pharmaceutical costs increased an average of twenty percent from 1999 (with less than five percent of those costs caused by inflation), while overall health care costs increased only twelve percent. Various reasons have been put forth for this dramatic increase in the cost of pharmaceuticals, including increased use of newer medications, increased utilization caused by factors such as more available insurance coverage (both health care and workers' compensation), increased use of treatment protocols that recommend pharmaceuticals, and the ageing of the American population.

Managed care organizations (MCOs), in both a workers' compensation and traditional health insurance context, seek to control the utilization and cost of pharmaceuticals through several key techniques. The primary mode of utilization control of prescribed drugs by MCOs includes the use of a prescription drug "formulary".¹⁴⁰ A formulary is a list of specific prescription medications, usually categorized by class of medications, from which participating physicians must choose drugs to prescribe, unless there is a medical contraindication to using a formulary drug. The most common way in which specific drugs are placed on a MCO's formulary is by vote of the members of the MCO's pharmacy and therapeutics (P&T) committee. The P&T Committee is commonly staffed by representatives of the MCO's medical and organizational staff (physicians and pharmacists), as well as physicians and pharmacists that treat the MCO's membership. Ideally, the pharmacists and physicians on the P&T Committee work to create a formulary that not only contains effective and efficacious pharmaceuticals, but also a formulary that meets the needs of their patients and members in the most cost effective manner. The P&T Committee most often initially determines which pharmaceuticals, by classification of drug, are safe and effective. Then, the relative cost of each drug is determined to identify the best value among similarly classified prescription drugs. This analysis by the P&T Committee may result in their recommendation that generic, or brand-name, drugs be placed on the formulary as preferred drugs if it is determined they meet the Committee's criteria for producing the same or better clinical responses. The analysis by the P&T Committee should be an on-going decision making process, utilizing recent medical literature and clinical studies to determine whether generic or brand name drugs, as appropriate, should be added to, or removed from, the MCO formulary.¹⁴¹

¹³⁹ In the report *The Study of the Cost of Pharmaceuticals in Workers' Compensation*, the authors projected the total Rx costs for pharmaceuticals in California to be more than \$350,000,000 by year 2005. *The Study of the Cost of Pharmaceuticals in Workers' Compensation*, Frank Neuhauser, Alex Swedlow, Laura Gardner and Ed Edelstein. Report commissioned by the Commission on Health and Safety and Workers' Compensation and the Department of Industrial Relations.

¹⁴⁰ Generally, HMOs use formularies more commonly than do PPOs, though with increasingly high drug costs as a component of workers' compensation medical care benefits (as well general health care), the use of formularies is increasing in more models of managed care organizations.

¹⁴¹ For a more detailed description of the principles that contribute to an MCO formulary, see "Principles of a Sound Drug Formulary System, October 2000", a guide to the development of formularies that is published by a coalition of national organizations representing health care professionals and government and business leaders that was formed in September,

MCOs also control the use of drugs through a process of drug utilization review.¹⁴² This process is similar to the process of utilization review that MCOs employ to control utilization of other medical treatment, whereby the MCO requires that certain drugs, or, in some cases the class of prescription drugs, be preauthorized by the MCO before they can be dispensed. Another tool to control the use of certain pharmaceuticals includes the requirement that the generic version of a drug should be dispensed to the patient unless there is some medical indication or medical preference for the patient only to use the brand-name version of a particular drug. This need to dispense the brand name, rather than the generic, is commonly indicated by the treating physician by writing “dispense as written” on the prescription.

A further technique employed by MCOs – although this technique is also used by non-MCO health insurance providers - includes the use of an organization known as a pharmacy benefit manager (PBM) to administer the pharmacy component of their medical benefits, and to help control the utilization and cost of pharmaceuticals. A PBM often administers pharmacy services to more than one MCO. As such, the PBM may represent many more members than are in the MCO, thus giving PBM an improved bargaining position with the drug manufacturers and distributors to secure better discounted drug prices.¹⁴³ Because the larger PBMs traditionally use highly sophisticated computerized utilization tracking tools, that are accessed by a large network of pharmacies, to authorize and monitor drug utilization, the information generated by a PBM can reflect drug utilization patterns and trends. By tracking and trending this information, the PBM, while working in conjunction with the MCO, can assist physicians in the monitoring of utilization rates of certain drugs and provide provider based education tools regarding certain drugs that can have harmful interactions or side-effects.¹⁴⁴

The application to the workers’ compensation arena of requiring generic drugs be dispensed unless the physician affirmatively indicates otherwise is seen through a report commissioned by the Commission of Health and Safety and Workers’ Compensation and the Department of Industrial Relations titled *The Study of the Cost of Pharmaceuticals in Workers’ Compensation*.¹⁴⁵ The authors of this report identified, as one of their recommendations, that the California workers’ compensation system should adopt a rule requiring a generic prescription drug, when available to help lower the cost of pharmaceuticals in that system.¹⁴⁶ In addition, this report also noted that the California Official Medical Fee Schedule at that time allowed for higher reimbursement rates than private HMO contracts.¹⁴⁷

1999. For example, this guide is endorsed by the Academy of Managed Care Pharmacy, the American Medical Association and the Department of Veterans Affairs (Pharmacy Benefits Management Strategic Healthcare Group), among others.

¹⁴² Often, the process of drug utilization review is abbreviated as “DUR”.

¹⁴³ These discounted prices negotiated by PBMs are commonly earned through rebates and administrative fees, with rebates usually shared with the client’s of the PBM and the administrative fees usually kept by the PBM.

¹⁴⁴ An example of how a PBM can assist in the monitoring of over-prescribing, or under-prescribing, of prescription drugs is the increased use of OxyContin. OxyContin is a highly addictive pain killer that, in certain parts of the United States, is becoming a highly sought after street drug that is sometimes over-prescribed to generate illegal kickbacks to the provider or to generate money for the recipient who sells the drug on the street.

¹⁴⁵ *The Study of the Cost of Pharmaceuticals in Workers’ Compensation*, Frank Neuhauser, Alex Swedlow, Laura Gardner and Ed Edelstein.

¹⁴⁶ In addition to the recommendation that generic drugs should be furnished, when available, *The Study of the Cost of Pharmaceuticals in Workers’ Compensation* also recommended that insurers and employers be allowed to control the dispensing of pharmaceuticals for the course of the claim, that the workers’ compensation fee schedule should be brought more in line with the industry averages of other states, and that insurers and employers should be provided with incentives to approve limited “first fill” prescriptions before a claim is accepted as compensable.

¹⁴⁷ Although not unique to MCOs, there are certain quality of care techniques and initiatives, both structural and procedural, that MCOs are embracing to improve the pharmaceutical services. One of these initiatives is the Leapfrog Organization

For a more general discussion of economic principles in a managed care setting, please refer to the chapter titled Evaluation of Pharmaceutical Costs and Outcomes in Managed Care Settings by Barbara Goppold and Becky Briesaher in *The Role of Pharmacoeconomics in Outcomes Management*, edited by Nelda E. Johnson, PharmD and David B. Nash, MD.¹⁴⁸ This report noted the role that the following three principles will play in managed care settings: the use of measurement and use of reliable outcomes data, the implementation of clinical practice guidelines and the assessment and managed of total health care costs for specific patient populations.

(which is sponsored by a consortium of over 500 large employer groups) that requires, among other initiatives, participating plans to use computer-based physician order entry (including prescriptions) to reduce the probability of mistakes occurring due to illegible writing. In addition, the advent of these computer-based medical records includes the use of computerized drug interaction protocols to check for possible negative consequences due to multiple prescriptions.

¹⁴⁸ *The Role of Pharmacoeconomics in Outcomes Management*, Nelda E. Johnson, PharmD and David B. Nash, MD, Editors.

IV. ACCREDITATION SERVICES FOR MANAGED CARE ORGANIZATIONS (General Discussion and Key Literature References)

Managed care systems, particularly those in the managed care health care arena, are constantly being asked to demonstrate that they provide high quality services. The need to demonstrate the quality of services rendered, health care or otherwise, has led to the development of systems to gauge the quality of the services provided so that both the purchasers and users of those services, as well as those who are considering purchasing those services, can make informed decisions.

One of the prime considerations for any workers' compensation managed care provider is the quality of the utilization review processes of an MCO plan.¹⁴⁹ As such, on September 30, 1996, the Utilization Review Accreditation Commission (URAC) announced the issuance of their new accreditation standards for workers' compensation managed care programs.¹⁵⁰ As of 1996, twelve states and Washington, D.C. required URAC accreditation for their workers' compensation managed care systems. As noted in the discussion of Category Two factors, ensuring that utilization management principles are appropriately changed to meet the unique needs of injured workers is vital to the success of a workers' compensation managed care system. Utilizing accreditation agencies that provide objective criteria for UM and QM standards could provide important objective criteria that states could incorporate into their certification process for workers' compensation MCOs. In addition, even if a state does not require an MCO to meet URAC standards, purchasers of workers' compensation managed care services can insist that their contracted MCO is certified by the appropriate agencies.

In addition to agencies such as URAC that tailor their accreditation standards to certain categories (such as utilization review) to meet the unique needs of workers' compensation requirements, there remain multiple generic managed care principles (Category One principles) that are important in managed care systems that cater to both workers' compensation and health care recipients. There are several accreditation agencies that include in their review criteria issues (Category One principles) that are important to any managed care entity, workers' compensation or otherwise.¹⁵¹

For instance, the National Committee on Quality Assurance (NCQA) offers a general one- or three-year accreditation status for managed care organizations. This accreditation status, while not directed to workers' compensation, addresses managed care principles such as credentialing, quality management, utilization management, access, and other general managed care principles. NCQA promulgates detailed standards for each of these categories that a plan must meet in order to become accredited by NCQA. One example of the type of managed care components that are taken into consideration by the NCQA standards is the "credentialing" of managed care providers. This credentialing accreditation requirement contains specific elements that must be confirmed by the MCO to meet NCQA accreditation standards in the credentialing category. Although these thirteen

¹⁴⁹ See discussion of the importance of Utilization Review in the discussion of the Category Two elements in workers' compensation managed care arrangements, *supra*.

¹⁵⁰ The President of URAC, Garry Carneal, noted in reference to these new standardized utilization review criteria for workers' compensation managed care: "[T]hese new standards ... are tailored to the specialized workers' compensation industry where managed care efforts are beginning to take hold."

¹⁵¹ One very recent addition to the arena accreditation is the July 27, 2001, approval by URAC's Board of Directors of their standards for its Health Web Site Accreditation Program. Given its recent release, no substantive literature references were found regarding this new website accreditation process. For a general discussion of the URAC Health Web Site Accreditation standards, please see the URAC web site (www.urac.org) for a summary of these new accreditation standards and the results of a consumer poll gauging the public's attitude toward health web sites and accreditation.

credentialing elements are unique to managed care, they nevertheless are key elements (such as licensure, completion of an appropriate residency, etc.) that help to assure that the members of that MCO, workers' compensation or otherwise, will receive a high quality care from their providers.

Another example of general accreditation organizations is the Joint Commission for Accreditation for Hospital Organization (JCAHO) standards specifically designed for preferred provider organizations (PPOs), recently revised for surveys occurring during 2001. For an overview of these new standards, please refer to the article titled *Updating PPO Accreditation – New Manual and Revised Survey Process for 2001*.¹⁵² This article discusses the popularity of PPOs as a delivery model, as well as the recently revised JCAHO standards and accreditation policies for PPOs that address the multiple dimensions of individual safety that are woven into the recently revised *Accreditation Manual for Preferred Provider Organizations (AMPPPO)*.¹⁵³ The new standards include new criteria for evaluating "enrollee participation" factors. These factors include a review of the plan's communication with the enrollee, the plan's complaint and grievance processes and how well the plan maintains the confidentiality of enrollee information.¹⁵⁴ New utilization management policies include an evaluation of the plan's ability to monitor medical necessity, appropriateness and efficiency of the health care services delivered to the enrollee, at least for PPO plans that provide these services.¹⁵⁵

Detailed standards, such as those provided by NCQA for credentialing providers, complement the very general structural and procedural requirements, such as for credentialing, that are present in the workers' compensation certification processes in many states. For instance, most states' workers' compensation managed care certification standards are limited to a general requirement that all providers must be "appropriately credentialed", without any further detail as to the credentialing standards.

V. AN INTRODUCTION TO THE MANAGED CARE PURCHASING POOL MODEL (General Discussion and Key Literature References)

As noted above, both HMOs and PPOs can utilize a variety of models, with each model emphasizing certain aspects of care to make its organization more effective in providing health care to its members. One of the newer delivery models is use of purchasing pools to purchase MCO services. Examples of purchasing pools in California include California Choice (CalChoice) and Pacific Health Advantage (PacAdvantage, which is administered by the Pacific Business Group on Health).¹⁵⁶ Both of these organizations limit their purchasing systems to health insurance only, but their principles could apply to the group purchasing of workers' compensation services.

In 1995, the California Small Business Association established the CalSERS program, which is a California corporation providing small business services and products through a purchasing cooperative to small employers. The self-described mission of CalSERS is to provide quality products and services through a purchasing pool at an affordable price and to make small businesses more competitive and profitable. Through the application of this concept, CalSERS merges the health component of mandatory worker's compensation insurance with employer's voluntary group health coverage, thereby providing a forum that can create loosely "integrated coverage" designed to reduce

¹⁵² Joint Commission Perspectives, March 2001, Volume 21, Number 3, page 4.

¹⁵³ Id.

¹⁵⁴ Id.

¹⁵⁵ Id.

¹⁵⁶ PacAdvantage was formerly known as the Health Insurance Purchasing Cooperative (HIPC), which was administered by the Managed Risk Medical Insurance Board (MRMIB).

premiums and increase health coverage for employees. Additional savings to this program, at least potentially, could be realized by introducing managed care concepts to the integrated system.

Both CalChoice and PacAdvantage pool together small employers (generally defined as those with two to fifty employees) who collectively create a single much larger pool of members. This single pool of members enjoys stronger purchasing power by virtue of its larger membership, thereby allowing these purchasing groups to receive better benefits at less cost. By pooling their resources, these smaller employers are afforded other value-added services, such as locked-in premiums that do not change more frequently than once per benefit year. In addition, small group employers and employees are given additional options in their choice of plans, something that was not traditionally available to small groups. For instance, under the PacAdvantage purchasing pool, members choose between four HMO plans (which vary, primarily, by price), two PPO plans, one POS plan and one “triple coverage plan” that gives members an HMO option, a PPO option and an out-of-network option under a single plan.

To date, neither CalChoice nor PacAdvantage offers a workers’ compensation option to their packages of services, where employers would enjoy the greater purchasing power by combining their workers’ compensation eligible employees into a single pool. However, for a cross-state detailed discussion of the small-group health insurance purchasing pools¹⁵⁷ model in California, Connecticut and Florida, please refer to *Have Small-Group Health Insurance Purchasing Alliances Increased Coverage* by Stephen H. Long and M. Susan Marquis.¹⁵⁸ This study reviewed the Health Insurance Plan of California (HIPC, now known as PacAdvantage), the Connecticut Business and Industry Association (CBIA) and the Florida Community Health Purchasing Alliances (CHPA). Each of these organizations offered a choice of plans (HMO, PPO and some POS plans). This study utilized data collected through the application of the 1997 Robert Wood Johnson Foundation (RWJ) Employer Health Insurance Survey and analyzed the effect of these pools by measuring changes in the market between 1993 and 1997 in California, Connecticut and Florida, compared to the rest of the country. The study revealed that each pool had captured a very low (two to six percent) of their state’s small group market and the pools did not appear to attract new employer groups to the health insurance market. This study also noted that these pools were relatively unknown to the majority of employer groups, and that the choice of plans offered to employees was broader than that traditionally offered to small-groups. The study noted that in California the purchasing pool offered significantly lower premiums than other plans in California, whereas the plans in Connecticut and Florida were statutorily prohibited from offering insurance at lower prices than broader coverage markets and therefore did not offer such premium savings. Whether such pools can increase coverage, which this study reflected that they did not significantly appear to do, could be increased by requiring organizations that offer plans in a small-group markets to participate in a small-group pool, or a requirement that small-group insurance only be offered through small-group insurance pools.

For a general discussion on the use of purchasing pools in the health insurance context, please refer to *HealthMarts, HIPCs, MEWAs, and AHPs: A Guide for the Perplexed*¹⁵⁹ This article considers the impact of several proposed group purchasing arrangements for health insurance, and whether these

¹⁵⁷ Small-group purchasing pools are also referred to as small-group purchasing *alliances* in the general literature relating to this topic.

¹⁵⁸ *Have Small-Group Health Insurance Purchasing Alliances Increased Coverage*, Health Affairs, January/February 2001, Volume 20, Number 1, Pages 154-163.

¹⁵⁹ *HealthMarts, HIPCs, MEWAs, and AHPs: A Guide for the Perplexed*, Health Affairs, January/February 2001, Mark A. Hall, Elliot K Wicks and Janice S. Lawlor, Volume 20, Number 1, pages 142-153. (HIPC is an acronym for Health Insurance Purchasing Cooperative (the former administrator of a small-group purchasing organization in California.) MEWA is an acronym for the multiple employee welfare arrangements. AHP is an acronym for association health plans.)

types of proposed arrangements would mesh with existing purchasing arrangements in the general regulatory framework. It also considers whether such purchasing pool arrangements would result in market efficiencies or would result in risk pooling behavior and concludes that while the details have yet to be finalized, premium reductions and increased coverage could result from the proposed purchasing pools. For additional information on emerging trends on new group purchasing pools and arrangements, please refer to an article titled *Consumer-Choice Purchasing Pools: Past Tense, Future Perfect?* This article reviews the various purchasing pool strategies used in several states to utilize group purchasing power to increase their options of insurance, and it discusses cooperative state and private organizations that work together to organize and comarket health care coverage through purchasing pools, such as in New York. This discussion includes a consideration of the use of consumer choice pools to purchase health care services, managed care and otherwise, with public financial contributions to cover the costs of care for low-income children. These systems have been endorsed by Kansas, Connecticut and Oregon. In addition, the article titled *Memphis Business Group on Health: a model for health care review and cost containment* describes a community based purchasing pool that includes a purchasing alliance for negotiating contracts for health care services and workers' compensation insurance products.¹⁶⁰

VI. 24-HOUR COVERAGE PROGRAMS

In the mid-1990s, a popular method that sought to lower the costs of workers' compensation was the application of "24-hour coverage" legislation and pilot projects in multiple states, including California. Although multiple states enacted 24-hour coverage, the concept is not defined uniformly across the United States. Most 24-hour coverage programs seek to integrate (albeit with varying degrees of integration) the administration of employer-based workers' compensation insurance with the administration of employer-based health care and disability insurance. In its most integrated form, a single insuring or administering entity (e.g., an HCO, a traditional indemnity insurer, a workers' compensation insurer, a disability insurer, etc.) issues a single policy of coverage that encompasses coverage not only for workers' compensation events but also for general health and disability events, thereby providing medical and disability services for employees both during and outside of work. In other words, that single integrated policy addresses disability and health coverage issues "24-hours" per day.¹⁶¹ As the health insurance vendor that provides the occupational and/or non-occupational

¹⁶⁰ Managed Care Quarterly, Winter 1994, 2, page 1.

¹⁶¹ For a further discussion on the varied definitions of 24-hour coverage, please see the report by the Research and Evaluation Unit of the California Division of Workers' Compensation entitled *Interim Report to the Legislature: 24 Hour Pilot Programs under Labor Code Section 4612* citing to Peter Barth, Ph.D. "What is 24 Hour Coverage." Paper prepared for 24 Hour Coverage Symposium, Philadelphia, PA, September 6, 1995. As the Interim Report states:

"[t]here is no single definition of 24 Hour Care. At one end of the spectrum, the term implies a seamless health and disability system, providing medical care and indemnity benefits to those unable to work, whatever the cause of injury and illness. Twenty four hour care may also describe a coordinated system of health care delivery, whereby a person receives all medical care for injuries and illnesses from a single health care provider. To some, it means that claims from various benefit systems are handled by the same party or at the same location. It may also mean a system of coordinated claims settlements to eliminate duplicate claim filings involving medical, disability, accident, disease, and other forms of coverage. The National Association of Insurance Commissioners uses the working definition "any combination of traditional health insurance and workers' compensation insurance that attempts to dissolve the occupational and nonoccupational boundaries between the two coverages."

health care can provide services under any model of health care delivery (managed care, fee-for-service, preferred provider systems, etc.), the concept of 24-hour coverage does not necessarily integrate managed care concepts. However, the use of managed care entities (e.g., Kaiser Permanente (KOJ) in California) is a common delivery model that is used to supply 24-hour coverage.

A key motivating principle for integrating services in a single 24-hour coverage policy is to eliminate the inefficiencies that result from the potentially overlapping and occasionally conflicting provisions when a single employer utilizes separate policies from different vendors to meet the health, compensation and disability needs of its employees. These inefficiencies, at least potentially, hinder the common goals of employers, employees and the insurers. For example, a worker whose injury is compensable under a state's workers' compensation system may also qualify for benefits under her employer's disability insurance policy as a result of that injury. At the same time, that same injured employee might continue to seek general medical care under her employment provided health insurance for illnesses and injuries that are not causally connected to her compensable injury, illnesses and injuries which may or may not render that employee disabled. While the care and benefits rendered to a single employee pursuant to three different policies may be contractually and legally distinguishable to the three different insurers, those distinctions will be less clear to the employer, employee and providers. This confusion can lead to a less efficient provision of services and redundancies. These inefficiencies can exist in spite of the common goals of the three insurers, the employer and the employee (e.g., return the employee to a healthy state, return the employee to work, reduce lost time from work by maximizing the employees residual capacity, etc.). Each insurer (as well as the employer and injured employee) may work to achieve these common goals through conflicting and/or redundant methodologies, thereby creating additional expense.

For example, if a worker suffers a compensable injury the disability insurer carrier and the workers' compensation carrier both share the common goal of returning the injured employee to work. Both organizations, if they are not integrated, may subject the employee to two different return-to-work programs that do not approach their common goals with a concerted or common strategy. In addition, two different doctors (one authorized by the general health insurance and the second authorized by the compensation insurance) may be trying to treat two injuries with protocols that do not compliment one another. By utilizing a common system to provide health, disability and workers' compensation benefits (which can be further integrated in a managed care system), services can be provided with greater integration and efficiency.¹⁶² For example, case managers and adjusters can work together to more closely coordinate care, thereby more effectively reducing the possibility of an employee or provider filing duplicative claims for the same illness or injury.

While the potential cost savings of an integrated system are easily discernable, the integration of disparate health, disability and compensation coverage is not necessarily easy. Implementing a system of twenty-four hour coverage can be a complex and expensive process, depending on the compatibility of the separate systems (e.g., integrating data systems; specialized training for providers, brokers and adjusters, gaining regulatory approval, etc.).¹⁶³

¹⁶² See this report, Section II, Category (a) for a more detailed discussion regarding the concept of integration in the delivery of managed care.

¹⁶³ See *Interim Report* at 3.

As noted above, 24-hour coverage programs were introduced to the California workers' compensation system as legislated pilot programs in 1992¹⁶⁴, with the intent of lowering the cost of workers' compensation insurance by improving the efficiency of care provided to injured workers. However, the time during which these pilot programs were being implemented in California corresponded with the substantial lowering of rates for reasons unrelated to the 24-hour coverage pilot programs. As such, the enrollment and participation in these programs, which sought to lower workers' compensation costs for employers was not notable in the formative years of the pilot program. However, with increases in workers' compensation premiums during the last few years to pre-reform levels, increases have been seen both in the enrollment and participation of HCOs in California.¹⁶⁵

Several commissioned studies in California examined various aspects of the 24-hour coverage program, as was required by the enabling legislation. The study entitled *Evaluation of California's 24-hour Coverage Pilot Demonstrations* sought to determine whether 24-hour coverage reduced the costs of medical claims for compensable injuries and whether the employees enrolled in the 24-hour coverage program systemically differed employees who chose not to enroll in the program.¹⁶⁶ The study compared the claims generated by Kaiser Permanente's 24-hour program (KOJ) against Kaiser fee-for-service claims and control firms. In summary, this study found that:¹⁶⁷

- Pilot firms had a substantial cost advantage prior to joining the 24-hour coverage pilot programs, particularly among their Kaiser FFS claims.¹⁶⁸
- Between 1992 and 1997, the average cost of claims declined more within control firms than in pilot firms.¹⁶⁹
- The 24-hour pilot programs produced *lower* claims costs (4.7 to 6.5%) for temporary and permanent disability cases, but *higher* claims costs (20 to 34%) for medical only claims.¹⁷⁰
- Overall, pilot firms paid 47.5% *more* in total KOJ premiums than if they had paid for KOB claim (*sic*) on a FFS basis.¹⁷¹
- Satisfaction with pay, age, and certain chronic conditions increased the odds of enrolling in the pilot program, while perceived job risk, minority ethnicity status, and professional occupation decreased the odds of enrolling. [The study's] findings suggest that employee trust may play an important role in determining if managed care can be successfully used in state workers' compensation programs.¹⁷²

A second California study entitled *Injured Worker Satisfaction with Care in a 24-Hour Pilot Program* noted "no significant differences in patient satisfaction with care or outcomes in injured workers

¹⁶⁴ Id. The original legislation introducing 24-hour care (AB 3757) was introduced in February 1992 and was signed into law by Governor Wilson in October 1992 (Labor Code Section 4612). Section 4612 of the Labor Code was subsequently amended in 1993 and 1994 to address issues such as the scope of the program as well as the evaluation of the program.

¹⁶⁵ An October 10, 2002, California Workers' Comp Advisor notes that as of October 10, 2002, enrollment in California HCOs was approximately 200,000. Due to the number of new HCOs, and consequential reporting difficulties, the current enrollment is being revised.

¹⁶⁶ *Evaluation of California's 24-Hour Coverage Pilot Demonstrations*, Final Report submitted to the Robert Wood Johnson Foundation and the California Department of Industrial Relations, Division of Workers' Compensation, Kominski, Gerald, et al., November 2001.

¹⁶⁷ Id at 4.

¹⁶⁸ Id.

¹⁶⁹ Id.

¹⁷⁰ Id.

¹⁷¹ Id.

¹⁷² Id at 36.

receiving usual care versus 24 hour care¹⁷³” although the authors noted that due to the limitations of the study the results should not be over-interpreted.¹⁷⁴

In addition to the 24-hour coverage pilot program in California, other states implemented 24-hour pilot projects and programs. Many of these programs and pilots, like the pilot in California, were conceived legislatively during the 1990s when workers’ compensation premiums were rising. Like the California 24-hour coverage pilot project, other states have implemented 24-hour coverage programs (or pilots) to counter increasing workers’ compensation costs to the state and employers.

In 1995 the Minnesota legislature established the requirement that a 24-hour pilot project be implemented, with the actuarial firm of Milliman and Robertson prospectively concluding that such a program could save “between a 3.5 percent savings and a 2 percent increase in total costs.”¹⁷⁵ In 1994, the Maine Bureau of Insurance established standards and procedures for 24-hour coverage projects but as of December 6, 2002 no 24-hour coverage project application has been approved in the Maine program. The Maine Bureau of Insurance 2002 Report to the Maine Legislature (Joint Standing Committee on Banking and Insurance) noted that some reasons for the lack of interest in its 24-hour coverage pilot program include “the employer/insurer’s ability to select a health care provider for the injured worker during the initial 10 days, changes in workers’ compensation in 1993 that reduced costs to employers, and ERISA preemption issues” as well as a national shift away from 24-hour coverage. A similar 24-hour coverage program was begun in Kentucky in 1995, with the Kentucky Department of Insurance being mandated to establish administrative regulations authorizing 24-hour coverage pilot projects. Oregon and Washington likewise established 24-hour coverage pilot programs during the mid-1990s. However, most of these programs were conceived during a period of time in which workers’ compensation costs were escalating, but they were implemented when costs were falling. As such, employers during the mid-to late 1990s were not under any financial incentive to participate in 24-hour coverage pilot projects. This phenomenon was, at least in part, responsible for the early low enrollment in many 24-hour pilot projects. However, with compensation costs increasing again, it is likely that the interest in the potential cost-savings principles in 24-hour coverage will be rekindled. For instance, the Texas Research and Oversight Council on Workers’ Compensation has identified 24-hour coverage in its 2003 Research Agenda, specifically the “[a]nalysis of 24-hour coverage programs (workers’ compensation and group health coverage combined) in other states and the applicability of 24-hour coverage options in the Texas workers’ compensation system.”

¹⁷³ An additional study entitled *What Do Injured Workers Think About Their Medical Care and Outcomes After Work Injury* utilized a standardized self-administered questionnaire to collect data regarding patient satisfaction and outcomes for compensably injured workers in California who were enrolled in one of the four following organizations: a state-certified HCO, the California 24-hour pilot program, obtained care at one of two large MCOs that contract with employers to provide workers’ compensation services, or, were employed by one of five large self-insured employers. This report generated valuable information regarding worker perception about their experiences with the California Workers’ Compensation. While 24-hour care pilot program workers were respondents in this study, the Research Brief did not differentiate the worker responses by enrollment in 24-hour pilot projects.

¹⁷⁴ *Injured Worker Satisfaction with Care in a 24-Hour Pilot Program*, Rudolph, Linda, et al., Division of Workers’ Compensation, California Department of Industrial Relations (2001) at 7.

¹⁷⁵ Executive Summary of the Minnesota Department of Health’s Health Economics Program (HEP) entitled *24-Hour Coverage (1996)*.

VII. WORKERS' COMPENSATION AND MANAGED CARE - General Literature Review

1) *Workers' Compensation Managed Care Pilot Project, Final Report to the Legislature, Washington Department of Labor and Industries, University of Washington Department of Health Services, April 1997*

The State of Washington, in conjunction with the University of Washington Department of Health Services, developed and implemented this ground breaking study that directly compared, in a matched control-group designed study, the provision of managed care medical benefits to fee-for-service medical care benefits.

In 1993, Section 43.72.860 of the Revised Code of Washington (RCW) established the authority of the Department of Labor and Industries and the Workers' Compensation Advisory Committee to conduct pilot projects to purchase medical benefits for injured workers through managed care arrangements. This legislation also mandated that the pilot projects should be limited to specific employers and employees agreeing to the terms of the pilot, and the intent of the pilot ultimately established was to assess the overall effectiveness of managed care in a workers' compensation system, as compared to a fee-for-service system, by evaluating "the impact of managed care on: medical and disability costs, quality of care, worker satisfaction with medical care, and employer satisfaction."¹⁷⁶ These workers' compensation managed care pilot projects were designated to conclude no later than January 1, 1997, and were known collectively as the Managed Care Pilot (MCP).

In the pilot study, 120 firms joined the MCP as volunteer employer participants, representing 177 worksites and 7,041 workers, with three self-insured firms and 1,516 workers. All participating firms (employers), and thus their workers as well, were enrolled in the MCP by October 1, 1995, and workers who were injured on or before March 31, 1996, were required to seek treatment through one of the two participating managed care plans, Providence Health Plan (Providence) and Kaiser Foundation Health Plan of the Northwest (Kaiser). To better evaluate the effects of managed care, the evaluation compared the experience of the firms enrolled in the MCP in a matched control-group design, with a control group of workers who received their workers' compensation care by accessing a traditional fee-for-service system.¹⁷⁷

In summary, the major findings from the MCP evaluation, for medical and disability costs, were that the differences between the managed care group and the fee-for-service group differed only slightly (not statistically significant) with regard to disability costs and time loss duration. Out-of-network utilization was not highly controlled, with only 12% of the managed care injured workers receiving all their care in-network. There was no clear pattern of differences in utilization between both groups, for either inpatient hospitalization or outpatient surgical services, but outpatient utilization was lower for the managed care group (3.1 visits per claim as compared to 3.9 visits per claim). However, the total medical costs significantly differed between the two groups, with the managed care group incurring medical costs (dummy claims due to capitation payments) that were 27% lower, on average, and 32% lower with out-of-network claims excluded from the analysis.¹⁷⁸ There were no key differences in functional and medical outcomes in objective tests of residual function, though there was a five percent lower perception of overall outcome of treatment among the managed care group, as well as lower

¹⁷⁶ Workers' Compensation Managed Care Pilot Project, Final Report to the Legislature, Executive Summary, Washington Department of Labor and Industries, University of Washington Department of Health Services, April 1997, page i.

¹⁷⁷ Id at ii, iii.

¹⁷⁸ Id at viii.

“role function score” with regard to the activities of daily living.¹⁷⁹ Generally, the managed care group had lower patient satisfaction rates than the control group, though there was no significant difference in the number of workers’ returning to work after six months. Lastly, employers felt more involved, and ultimately became more involved, in the workers’ compensation claims of their employees and the process of returning them to work as a result of their participation in the MCP.

2) *Controlling Workers’ Compensation Medical Care Use and Costs Through Utilization Management, Journal of Occupational and Environmental Medicine, August 1999, Volume 41, No. 8, Pages 625-631, by Thomas M. Wickizer, PhD, MPH, Daniel Lessler, MD, MHA, and Gary Franklin, MD, MPH.*

This study examined the methods of utilization management (UM), and the effects of those methods on the patterns of care, on 9319 workers’ compensation patients. Specifically, the study examined the hospitalization of injured workers (denials for admission or restricted length of stay), the procedures more affected by UM procedures and the cost savings associated with UM review.

The study focused on preadmission authorization and concurrent review for a single, albeit large and well established, UM firm. This authors of this study reported that, overall, only a small percentage of requests were denied for preadmission (2% inpatient, 3% outpatient), but that initial denial rates for specific procedures were higher (e.g., 5.5% denied for spinal surgery other than fusion, 8.6% for carpal tunnel surgery) although with subsequent requests these denials were usually reversed. The clinical basis for the denial was not reviewed due to the proprietary nature of the utilization review guidelines, but the high reversal rate caused the authors of this study to raise questions about the sophistication and clinical basis underpinning the review procedures of the UM procedures.

The authors noted also that UM programs have potential to generate cost savings for employers and insurers as, through preadmission and concurrent review, the UM procedures reduced hospital admissions and the length of stay (LOS), as well as the number of outpatient diagnostic and surgical procedures, which resulted in a general estimated cost savings of \$5.4 million dollars (without deducting the costs to the administrative costs of the UM program). The authors of this study concluded that more reliable, empirical information is needed to assess the value of UM processes in the workers’ compensation context in order to determine if such programs will generate a “reasonable ‘return on investment’ for employers”. These additional analyses regarding the cost/benefit of UM programs in a workers’ compensation context must take into account issues such as utilization review reversal rate, the specific types of procedures or requests being reviewed or denied in the UM program and what sort of review (concurrent or preauthorization) is being considered.

3) *Managed Care and Medical Cost Containment in Workers’ Compensation, A National Inventory, 1998 – 1999 WC-98-7, Workers’ Compensation Research Institute, Ramona P. Tanabe.*

This report is the fifth update of the 1990 National Inventory report issues by the Workers’ Compensation Research Institute on managed care and medical cost containment in workers’ compensation. The primary purpose of this report was to determine the strategies in all nonfederal workers’ compensation jurisdictions in the United States and how those strategies can be applied to the regulatory environment of workers’ compensation. The data collected for this survey was produced

¹⁷⁹ Id at x.

through a survey sent to the heads of the workers' compensation systems in all fifty states and the District of Columbia.

This report presents an overview, including strategies and definitions, of the medical cost containment processes utilized by all workers' compensation jurisdictions. Medical fee schedules and the regulation of hospital payments are one such cost containment strategy, utilized at the time of the study in forty jurisdictions. This section includes a discussion and summary of medical fee schedules, including the use of the Medicare Resource-Based Relative Value Scale (RBRVS), the California relative value study, as well as base conversion factors or fee levels on charge data from other payers. Hospital payment regulations are also reviewed, with forty-two of fifty-one jurisdictions report to have the statutory authority to regulate hospital charges. The enforcement of medical fee schedules and hospital payments are also discussed.

In addition, this report includes a discussion and summary of the jurisdictional differences with regard to cost containment strategy of limiting an employee's choice of treating provider, as well as the ability of a worker to change providers once care has started. Fourteen states allow the employee to choose their provider initially without restriction, with the number of jurisdictions that allow unrestricted selection of a provider by the employee being reduced by fifty percent with the advent of managed care programs in their workers' compensation statutes. Only three states allow an employee to change providers without restriction, and seven states allow a change to occur at least once.

Managed care is also detailed extensively in this report as a cost containment strategy, including a discussion of the definition of managed care, the levels of services provided under such programs as well as managed care in a workers' compensation context. Managed care jurisdictions are categorized in this report as regulated, regulated but not mandated or unregulated, and this report discusses the extent to which a managed care organization (MCO) can successfully control costs and improve quality as a function of whether workers' receive care from an established provider network. A discussion of the concept of MCO certification as managed care workers' compensation providers is also included, as well as a summary of the ways in which MCO certification is undertaken in different jurisdictions. Also included is a discussion and summary of the other key elements of a workers' compensation MCO, including the use of provider network requirements, utilization review/management techniques, case management services, quality assurance programs, treatment guidelines and internal dispute resolution mechanisms.

4. *Review, Regulate, or Reform? What Works to Control Workers' Compensation Medical Costs*, Workers' Compensation Research Institute WC-94-5, September 1994, Thomas W. Grannemann, Editor

This collection of conference papers was produced by a wide variety of workers' compensation scholars, and includes several papers on the integration of managed care systems as a method of containing medical costs in the workers' compensation system, as seen during the era of President Clinton's attempt at health care reform. Although managed care principles appear throughout the volume (including chapters that focus on quality of care, payment rates, financing and delivery systems), managed care concepts are discussed most prominently in the "Managed Utilization" chapter. Though this volume was compiled in 1994, and thus discusses workers' compensation medical costs in the beginning of the workers' compensation managed care phenomena and in context of the (then) pending Clinton health care reform legislation, it outlines several key policy issues and discussion that remain germane in the context of today's workers' compensation managed care arena.

For instance, in the Managed Utilization chapter, Joseph Newhouse, in his article titled *Impact of Cost Sharing and UMO on Utilization and Health Status*, uses the RAND Health Insurance Experiment to compare FFS systems of care with HMOs systems of care, including the effects of these systems on use of health care services and on the effects on the health status of those seeking care under these two systems. In the same chapter, Jon Christianson reviews, in his article titled *Can HMOs Contain Workers' Compensation Medical Costs?*, various research findings to review whether HMOs control utilization costs and how these costs savings are achieved (where savings are realized) and how these savings can be applied to the workers' compensation context. The author notes the ambiguity in the general literature as to whether HMO use results in premium savings relative to traditional medicine and indemnity insurance plans, depending on the HMO model being analyzed, the population being served and the market in which the HMO operates. The author further notes the limited evidence, in 1994, which indicated both potential cost savings and potential cost increases with the advent of HMOs in the workers' compensation system.

The article further explores the application of HMO models to contain workers' compensation costs in the context of the Clinton health care reform. In the article title *The Impact of Managed Care on Workers' Compensation Claim Costs*, authors David Appel and Philip S. Borba note the strong evidence of the potential of managed care to help control medical costs in workers' compensation. In the article *Oregon's Approach to Workers' Compensation Managed Care*, Sara Harmon reviews the basic components of Oregon's (then) recently enacted managed care workers' compensation legislation.